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

JUNE 1, 2023
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

Clayton Corwin, Chair	Blair Contratto, Vice Chair
Isabel Becerra	Supervisor Doug Chaffee
Clayton Chau, M.D.	Norma Garcia Guillen
José Mayorga, M.D.	Supervisor Vicente Sarmiento
Nancy Shivers, R.N.	Trieu Tran, M.D.

Supervisor Donald Wagner, 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_5IsepLRLRYmm7DD05opXsA and Join the Meeting.
Webinar ID: **811 7071 1097**
Passcode: **339611** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS
1. Chief Executive Officer Report

2. Reserve Policy Review

3. Transplant Update

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

CONSENT CALENDAR
4. Minutes
   a. Approve Minutes of the May 4, 2023 Regular Meeting of the CalOptima Health Board of Directors
   b. Receive and File Minutes of the March 9, 2023 Special Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee

5. Authorize and Direct Execution of Amendments to CalOptima Health's Primary Agreement with the California Department of Health Care Services Related to Rate Changes

6. Adopt Resolution No. 23-0601-01, Authorizing and Directing Execution of Contract MS-2324-41 with the California Department of Aging for the Multipurpose Senior Services Program for Fiscal Year 2023-24

7. Approve New CalOptima Health Policy GG:1667: CalAIM Population Health Management Program

8. Approve New CalOptima Health Policy GG.1707: Doula Services

9. Approve New CalOptima Health Policy ITS:1308p DHCS 834 Eligibility Process

10. Approve Updated CalOptima Health Office of Compliance Policy HH.1107

11. Approve Actions Related to an Existing Contract for Zscaler to Include Zero Trust Network Architecture

12. Authorize Amendment to the Standard Grant Agreement to Reflect Updated Insurance Requirements

13. Authorize Extending Contract with the Infomedia Group Inc. dba Carenet Healthcare Services for one year

14. Approve Actions Related to State Advocacy Services

15. Adopt the Proposed CalOptima Health Board of Directors Meeting Schedule for Fiscal Year 2023-24

16. Receive and File:
    a. April 2023 Financial Summary
    b. Compliance Report
    c. Federal and State Legislative Advocates Reports
    d. CalOptima Health Community Outreach and Program Summary
    e. Digital Transformation Update

REPORTS/DISCUSSION ITEMS

17. Election of Officers of the Board of Directors for Fiscal Year 2023-24

18. Approval of the CalOptima Health Fiscal Year 2023-24 Operating Budget and Non-Operating Items

19. Approval of the CalOptima Health Fiscal Year 2023-24 Routine Capital and Digital Transformation Year Two Capital Budgets

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

21. Approve Actions Related to Wellness Prevention Foundation, dba Wellness & Prevention Center *allcove*™ South Orange County Mental Health Youth Center

22. Authorize Creation of a CalOptima Health Provider Workforce Development Reserve Fund

23. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Certain Health Networks to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

24. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Hospitals Except Fountain Valley Regional Hospital & Medical Center, Los Alamitos Medical Center and Placentia Linda Hospital, to Support Expenses for Services Provided to Members During the Transition out of the Public Health Emergency

25. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Fee-for-Service Hospitals Fountain Valley Regional Hospital & Medical Center, Los Alamitos Medical Center and Placentia Linda Hospital, to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

26. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Community Clinics AltaMed Health Services Corporation, to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

27. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Community Clinics, except AltaMed Health Services Corporation, to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

28. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Fee-for-Service Physicians to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

29. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Behavioral Health Providers to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

30. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Ancillary Providers to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

31. Authorize Amendments to the CalOptima Health Medi-Cal Health Network Services Contracts, Effective July 1, 2023

32. Authorize Amendments to the CalOptima Health Ancillary Contracts with Community Supports Providers to Incorporate Enhanced Care Management Program Services in Accordance with Department of Health Care Services Requirements, Effective July 1, 2023

33. Approve Amendments to the Medi-Cal Mental Health Non-Applied Behavioral Analysis and Applied Behavioral Analysis Provider Contracts

34. Approve Rate Increase for Contracted Medi-Cal Community-Based Adult Services Providers and Authorize Prospective Contract Amendments to Update Payment Rates

35. Authorize Assignment of the Restated Medi-Cal and Medicare Health Network Contracts with ARTA Western California Inc. dba Optum and Talbert Medical Group P.C. dba Optum to Monarch Health Plan, Inc.

CLOSED SESSION

CS-1. CONFERENCE WITH REAL PROPERTY NEGOTIATORS Pursuant to Government Code Section 54956.8
Under Negotiation: Price and terms of payments
Property: 7900 Garden Grove Avenue, Garden Grove, CA 92841
Agency Negotiators: David Kluth, and Mai Hu, Newmark Knight Frank
Negotiating Parties: Lvt, Inc.

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 June 1, 2023 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_5IsepLRLRYmm7DD05opXsA

To **Join** from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join.
https://us06web.zoom.us/s/81170711097?pwd=ZE5IRzhMQjNnV21xcnJCVUtWWUZlUT09

Passcode: 339611

Or One tap mobile:
+16694449171,,81170711097#,,,,*339611# US
+17193594580,,81170711097#,,,,*339611# US

Or join by phone:
Dial(for higher quality, dial a number based on your current location):
US: +1 669 444 9171 or +1 719 359 4580 or +1 720 707 2699 or +1 253 205 0468 or +1 253 215 8782 or +1 346 248 7799 or +1 646 558 8656 or +1 646 931 3860 or +1 689 278 1000 or +1 301 715 8592 or +1 305 224 1968 or +1 309 205 3325 or +1 312 626 6799 or +1 360 209 5623 or +1 386 347 5053 or +1 507 473 4847 or +1 564 217 2000

Webinar ID: 811 7071 1097
Passcode: 339611

International numbers available: **https://us06web.zoom.us/u/kcGvK0SAbm**

MEMORANDUM

DATE:	May 26, 2023
TO:	CalOptima Health Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — June 1, 2023, 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. Board of Supervisors Appoints New CalOptima Health Director

On May 23, the Orange County Board of Supervisors unanimously appointed Norma García Guillén to the CalOptima Health Board of Directors to complete an unexpired term ending on August 3, 2024, for the vacant seat to be held by "an accounting or public finance professional, or an attorney who is an active member of the State Bar." Ms. García Guillén is an experienced litigation attorney and founding Partner at Garcia Rainey Blank & Bowerbank LLP in Costa Mesa. She is expected to participate in her first Board meeting on June 1.

b. Update on Street Medicine Program

I am proud to report that our street medicine program has made significant strides in providing health care and social services to the unhoused population of Garden Grove over the past two months. Over the course of this time, Healthcare in Action has successfully outreached to 119 individuals and now has 50 active participants in the program. This is a conversion rate of over 40% and speaks to their consistent and compassionate methods of care. These numbers demonstrate the true importance of rapport-building and meeting our members in their own environment.

c. Press Conference Announces Social Worker Stipend Program With Cal State Fullerton

On May 16, CalOptima Health held a successful media event at California State University Fullerton (CSUF) with Supervisors and CalOptima Health Board Members Doug Chaffee and Vicente Sarmiento to announce our $5 million Board-approved funding for students in CSUF's Master of Social Work program. Over the five-year funding period, 115 students will receive $20,000 each year of the two-year program. As a result of the event and press release distribution to the media, CalOptima Health received coverage from the following news outlets:

- Orange County Register
- KFI Radio
- NewsWise.com
- The Epoch Times
- Excelsior
- Univision Channel 34
- Telemundo Channel 52
- Estrella Media Channel 62

d. CalOptima Health Government Affairs Updates

Gavin Newsom Releases May Revise

On Friday, May 12, Gov. Gavin Newsom released his Fiscal Year (FY) 2023–24 Revised Budget Proposal, known as the May Revise. Despite a $31.5 billion deficit, the May Revise continues to reflect full funding of recent Medi-Cal investments and priorities. Notably, the May Revise proposes to re-enact the Managed Care Organization (MCO) tax, retroactively effective April 1, 2023, through December 31, 2026, generating total revenue of $19.4 billion dedicated to the following purposes:

- $8.3 billion General Fund offset to support a balanced budget over the 3.75-year lifetime of the MCO tax.
- $11.1 billion in provider investments over 8–10 years, including Medi-Cal rate increases for primary care, maternity care and non-specialty mental health services to at least 87.5% of Medicare rates, effective January 1, 2024.

In addition, the May Revise includes these new investments that may impact CalOptima Health:

- $480 million for the state's BH-CONNECT Demonstration to support a new behavioral health workforce development initiative.
- $150 million for a new Distressed Hospital Loan Program to provide interest-free loans to not-for-profit and public hospitals in significant financial distress, in order to prevent their closure or facilitate their reopening. This money was made immediately available as a result of an "early action" budget bill (AB 112) signed into law on May 15.

Next, Gov. Newsom and the State Legislature will negotiate a final budget that must be passed by June 15 and signed by July 1.

State Legislator Submits Street Medicine Budget Request

State Assemblywoman Laurie Davies has submitted an official request to the Assembly Budget Committee to allocate $3 million in the upcoming FY 2023–24 state budget toward the expansion of CalOptima Health's Street Medicine Program. However, due to the growing state deficit, it remains unclear how many budget requests will be accepted and included in the final budget, which is expected to be enacted on July 1. CalOptima Health also submitted a federal earmark request for the same initiative to several Congressional offices in March, but we have not yet received formal decisions on whether any offices will sponsor that request in the FY 2024 federal budget.

Board of Supervisors Approves Medi-Cal Renewal Resolution

On May 23, the Orange County Board of Supervisors also unanimously approved a resolution introduced by Orange County Supervisors Vincent Sarmiento and Doug Chaffee "proclaiming the resumption of [the] Medi-Cal redetermination process as a serious risk to the continued health care coverage of CalOptima Health members and recognizing the collaboration of the Social Services Agency, CalOptima Health, and many community partners in helping our most vulnerable residents retain their health care." I attended the meeting and provided public comments in support of the resolution. This follows the adoption of a similar resolution by the CalOptima Health Board on May 4. CalOptima Health's Government Affairs staff will leverage this most recent action to further engage local governments and legislative offices to raise awareness about Medi-Cal renewal.

CalOptima Health Expands Medi-Cal Renewal Partnerships

CalOptima Health's Government Affairs team is working at all levels of government to expand awareness of Medi-Cal renewals, based on the Board's passage of the related resolution. To support these partnerships, we have provided modified flyers and posters that allow cities throughout Orange County to co-brand with CalOptima Health and the County of Orange Social Services Agency

(SSA). Several legislative offices have already committed to distributing co-branded materials to their constituents as well as posting on social media, and we are now engaging with key cities to encourage creating Medi-Cal Renewal Month of Action proclamations and hosting community events. This effort started with a presentation at a Stanton City Council meeting, described below.

Stanton City Council Meeting Features CalOptima Health Information
On May 10, I presented before the Stanton City Council to share information about CalOptima Health, including our mission, street medicine program and CalAIM initiatives. Central to my remarks was an update on Medi-Cal renewal and the urgency for local governments to partner with CalOptima Health to raise awareness. I asked the City Council to help our efforts by:

- Joining our renewal campaign
- Adopting a renewal proclamation
- Co-hosting a renewal/enrollment event with CalOptima Health and SSA in city limits
- Using our renewal toolkit materials

e. Breast Cancer Screening Pilot Debuts at City of Hope

As part of the Comprehensive Community Cancer Screening and Support Program, CalOptima Health launched a breast cancer screening pilot on May 1 to facilitate access for an initial cohort of 50 CalOptima Health Community Network members ages 50–74 to get their mammograms at City of Hope in Irvine. Health Education staff are calling members to conduct outreach and education and address barriers (such as transportation) to ensure members are connected to screening. Other efforts related to the project include collaborating with the Orange County Cancer Coalition to prioritize future strategies, engaging the Coalition of Orange County Community Health Centers to assess current screening capacity, and building relationships with other community-based organizations and health care providers to identify opportunities for partnership.

f. Health Literacy for Equity Training Offered for CalOptima Health Staff

CalOptima Health has launched a Health Literacy for Equity training program to improve organizational health literacy. The program is open to all employees and will help participants improve their ability to deliver information in an equitable way in service to our members. CalOptima Health is pleased to partner in this effort with the SSA, the Institute for Healthcare Advancement and St. Jude Neighborhood Health Center, with support from the Orange County Health Care Agency's Equity in OC grant.

g. Orange County Business Journal (OCBJ) Honors Outstanding CFOs

CalOptima Health's Chief Financial Officer Nancy Huang was honored as a nominee for this year's OCBJ CFO of the Year Awards. The awards recognize financial professionals for outstanding performance as corporate stewards for the preceding fiscal year.

h. Communications Department Wins Four Awards

On May 12, CalOptima Health's Communications team won four Finest Awards from the Health Care Communicators of Southern California for work on major projects in the past year:

- Gold: Special Publications – 2023 CalOptima Health Report to the Community
- Silver: Logo Creative/Brand Identity – CalOptima Health rebranded logo and name
- Bronze: Public Relations Campaign – CalFresh campaign
- Bronze: Ad Campaign – OneCare campaign

i. CalOptima Health Gains Media Coverage

- On May 8, CalOptima Health distributed a press release about the $25.5 million Board-approved Student Behavioral Health Incentive Program (SBHIP) funding to boost access to behavioral health care for K–12 children. The news was covered by New Santa Ana and other outlets.
- On May 9, CalOptima Health Medical Director and pediatrician Thanh-Tam Nguyen, M.D., provided tips on how to find a qualified and trustworthy pediatrician in a U.S. News online article.
- On May 22, Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, was quoted in The Washington Post in a story titled "Seniors Are Flooding Homeless Shelters That Can't Care for Them."
- On May 25, Carmen Katsarov, LPCC, CCM, Executive Director, Behavioral Health Integration, was featured in an ABC News segment on CalOptima Health's $25.5 million SBHIP funding for all 29 Orange County school districts.

CalOptima Health

Fast Facts
June 2023

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

Membership Data* (as of April 30, 2023)

Total CalOptima Health Membership

984,986

Program	Members
Medi-Cal	967,146
OneCare (HMO D-SNP)	17,406
Program of All-Inclusive Care for the Elderly (PACE)	434

*Based on unaudited financial report and includes prior period adjustment

Operating Budget (for 10 months ended April 30, 2023)

	YTD Actual	YTD Budget	Difference
Revenues	$3,472,811,712	$3,329,332,586	$143,479,126
Medical Expenses	$3,214,447,060	$3,121,837,529	($92,609,531)
Administrative Expenses	$151,833,358	$180,917,657	$29,084,299
Operating Margin	$106,531,294	$26,577,400	$79,953,894
Medical Loss Ratio (MLR)	92.6%	93.8%	(1.2%)
Administrative Loss Ratio (ALR)	4.4%	5.4%	1.1%

Reserve Summary (as of April 30, 2023)

	Amount (in millions)
Board Designated Reserves	$579.9*
Capital Assets (Net of depreciation)	$67.1
Resources Committed by the Board	$466.5
Resources Unallocated/Unassigned	$463.7*
Total Net Assets	$1,577.3

Total of Board designated reserves and unallocated resources can support approximately 103 days of CalOptima Health's current operations.

Total Annual Budgeted Revenue **$4 Billion**

NOTE: CalOptima Health receives its funding from State and Federal revenues only. CalOptima Health does not receive any of its funding from the County of Orange.

Back to Agenda

CalOptima Health Fast Facts

June 2023

Personnel Summary (as of May 6, 2023, pay period)

	Filled	Open	Vacancy %
Staff	1,287.1	107.8	7.73%
Supervisor	84	1	1.18%
Manager	107	9	7.76%
Director	58.5	11	15.83%
Executive Director	20	2	9.09%
Total FTE Count	1,556.6	130.8	7.75%

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

Provider Network Data (as of April 30, 2023)

	Number of Providers
Primary Care Providers	1,285
Specialists	8,286
Pharmacies	563
Acute and Rehab Hospitals	45
Community Health Centers	34
Long-Term Care Facilities	101

Treatment Authorizations (as of March 31, 2023)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	11.36 hours
Prior Authorization – Urgent	72 hours	13.09 hours
Prior Authorization – Routine	5 days	1.48 days

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

Member Demographics (as of April 30, 2023)

Member Age	
0 to 5	8%
6 to 18	25%
19 to 44	35%
45 to 64	20%
65 +	12%

Language Preference	
English	59%
Spanish	27%
Vietnamese	9%
Other	2%
Korean	1%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	39%
Expansion	38%
Optional Targeted Low-Income Children	8%
Seniors	9%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

CalOptima Health Hospital Payment Summary

Calendar Year (CY) 2020, CY 2021, and CY 2022 (Data Pull as of April 2023)

Notes:

- Includes Claims, Capitation, Supplemental Payments and "Paid" amounts from Encounter Submissions

- Report created based on payment dates

- 2022 Total is incomplete due to lag in claims and encounter submission

Group	Hospitals	2020 Total	2021 Total	2022 Total	Total
CHOC	Children's Hospital of Orange County	185,041,944	225,301,110	221,192,133	631,535,187
	CHOC Health Alliance (Phy Capitation)	140,676,364	166,524,323	154,356,491	461,557,178
	CHOC Children's at Mission Hospital	6,030,243	7,149,221	8,638,008	21,817,473
CHOC Total		331,748,551	398,974,654	384,186,632	1,114,909,838
UC SYSTEM	UCI Medical Center	156,248,150	216,053,487	206,961,774	579,263,411
	UCI University Physicians & Surgeons	75,538,481	85,503,384	3,821,819	164,863,684
UC SYSTEM Total		231,786,631	301,556,871	210,783,593	744,127,095
TENET	Fountain Valley Regional Hospital & Medical Center	196,589,007	214,067,722	206,696,014	617,352,744
	Los Alamitos Medical Center	7,689,702	10,550,560	11,865,027	30,105,289
	Placentia Linda Hospital	12,481,422	18,040,416	8,914,567	39,436,405
TENET Total		216,760,131	242,658,699	227,475,607	686,894,437
PROVIDENCE	Providence Mission Hospital	38,147,746	48,216,009	50,574,204	136,937,959
	Providence St Joseph Hospital	71,532,949	84,774,015	83,199,559	239,506,523
	Providence St Jude Medical Center	32,876,936	41,217,441	41,165,429	115,259,806
PROVIDENCE Total		142,557,631	174,207,464	174,939,192	491,704,288
KPC	Anaheim Global Medical Center	27,506,398	44,512,934	44,117,964	116,137,296
	Chapman Global Medical Center	13,530,065	18,998,450	19,429,657	51,958,172
	Orange County Global Medical Center	41,258,376	51,759,547	53,755,000	146,772,923
	South Coast Global Medical Center	24,562,198	34,607,504	33,959,885	93,129,587
KPC Total		106,857,037	149,878,436	151,262,505	407,997,979
PRIME	Garden Grove Hospital Medical Center	22,037,924	22,330,016	21,537,445	65,905,385
	West Anaheim Medical Center	34,776,174	43,082,409	42,243,917	120,102,500
	Huntington Beach Hospital	11,583,408	13,594,201	12,675,854	37,853,463
	La Palma Intercommunity Hospital	4,607,342	6,054,008	6,435,434	17,096,785
PRIME Total		73,004,848	85,060,635	82,892,651	240,958,133
Other Major Hospitals	Kaiser Foundation Hospital	24,311,374	69,577,486	70,334,964	164,223,824
	Hoag Memorial Hospital Presbyterian	47,819,918	64,449,226	63,577,989	175,847,132
	College Hospital Costa Mesa	33,659,825	40,776,006	41,782,215	116,218,046
	Cedars Sinai Medical Center	34,437,871	50,472,101	50,014,978	134,924,951
	Anaheim Regional Medical Center	43,795,732	56,702,206	52,343,211	152,841,149
	Foothill Regional Medical Center	31,114,315	37,179,215	34,101,859	102,395,389
	Orange Coast Memorial Medical Center	23,596,901	32,099,460	32,444,329	88,140,689
Other Major Hospitals Total		238,735,935	351,255,700	344,599,545	934,591,181
Grand Total		1,341,450,765	1,703,592,460	1,576,139,725	4,621,182,951

CalOptima Health

Our Mission

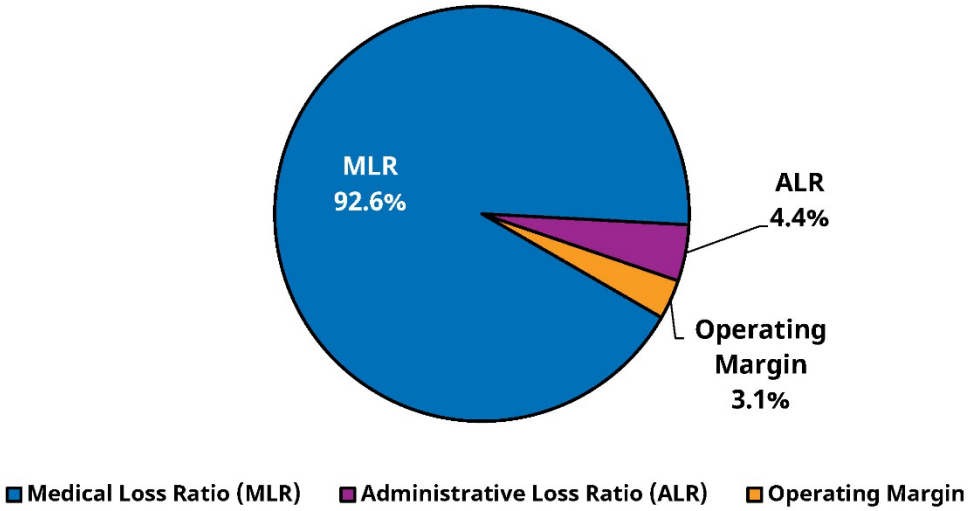
To serve member health with excellence and dignity, respecting the value and needs of each person.

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.

CEO Update

FY 2022-23 Annualized Financials

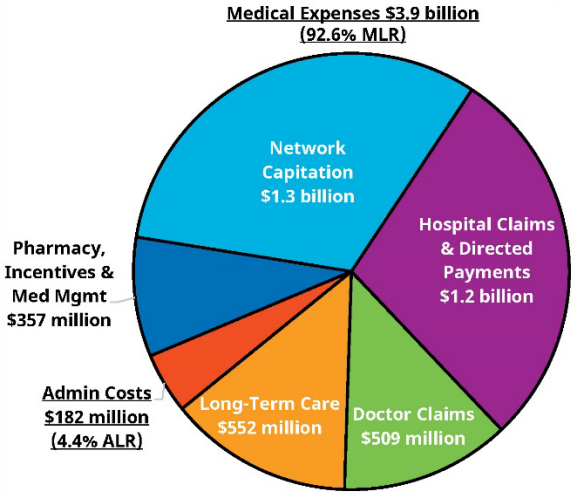


Note: The estimated 3.1% Operating Margin will go to CalOptima Health's total net assets, which will be available for Board allocation to support new initiatives in the Orange County community

CalOptima Health

How was the $4.0 Billion Allocated

FY 2022-23 Expenses by Category



Top Capitated Networks	FY 2022-23 Annualized Amount (millions)
Monarch Health Plan (HMO)	$323.5
CHOC Alliance (PHC)	$191.6
Kaiser Permanente (HMO)	$141.3
Prospect Health Plan (HMO)	$133.1
All Other Capitated Medical Groups	$494.9
TOTAL NETWORK CAPITATION	$1,284.5

Top Fee-for-Service Hospitals[1]	FY 2022-23 Annualized Amount (millions)
UCI Medical Center	$204.5
St. Joseph Hospital	$94.8
CHOC	$92.2
Fountain Valley Hospital	$88.3
All Other FFS Hospitals	$674.8
TOTAL HOSPITAL CLAIMS & DIRECTED PAYMENTS	$1,154.6

[1] By provider TIN, including IBNR and excluding Hospital Directed Payments
Note: All figures are annualized based on April 2023 YTD financials

CalOptima Health

3

FY 2022-23 Expense by Category

FY 2022-23 (Annualized as of 4/30/2023)	Amount (millions)
Medical Expenses	**$3,857.3**
Network Capitation	$1,284.5
Hospital Claims & Directed Payments	$1,154.6
Doctor Claims	$509.0
Long-Term Care	$551.7
Pharmacy, Incentives & Med Mgmt	$357.5
Administrative Expenses	**$182.2**
Salaries, Wages & Benefits	$123.9
Non-Salary Expenses: Operating & Others	$58.3
TOTAL	**$4,039.5**
MLR	***92.6%***
ALR	***4.4%***
Operating Margin	***$127.8 or 3.1%***

Net Asset Analysis

Reserve Summary (as of April 30, 2023)

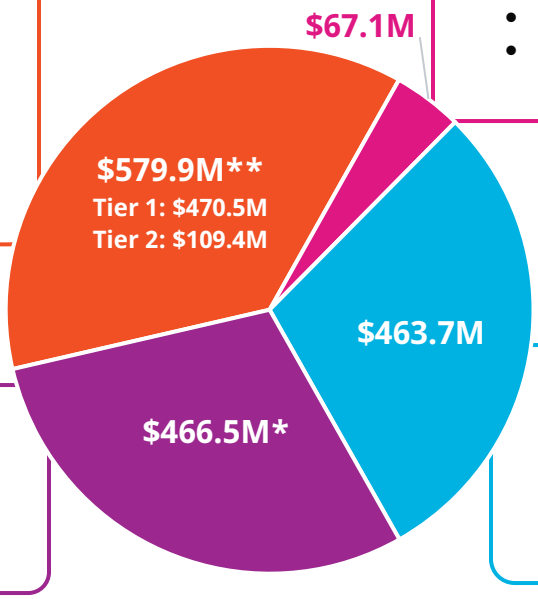
	Amount (in millions)
Board Designated Reserves	**$579.9***
Capital Assets (Net of depreciation)	**$67.1**
Resources Committed by the Board	**$466.5**
Unallocated Resources	**$463.7***
Total Net Assets	**$1,577.3**

Total of Board designated reserves and unallocated resources can support approximately 103 days of CalOptima Health's current operations.

Details on Reserves

Board Designated Reserves
- Tier 1: Board Designated Reserves
  Tier 2: TNE Requirement
- Board set the reserve level at 1.4 to 2.0 months of capitation ($579.9M is 1.91 months of capitation)

Capital Assets
- 505 and 500 Buildings
- Furniture, Equipment and Building Improvements



Committed by the Board
- Strategic Initiatives (HHI, DTS, IGT)
- Quality/Population Health
- Grant Programs

Unallocated Resources
- Board may use funds for new commitments
- Management may transfer funds to maintain adequate reserves

* Please see Exhibit 1 attached for information on Resources Committed by the Board
** Please see Exhibit 3 for the Board Designated Reserves Analysis

CalOptima Health

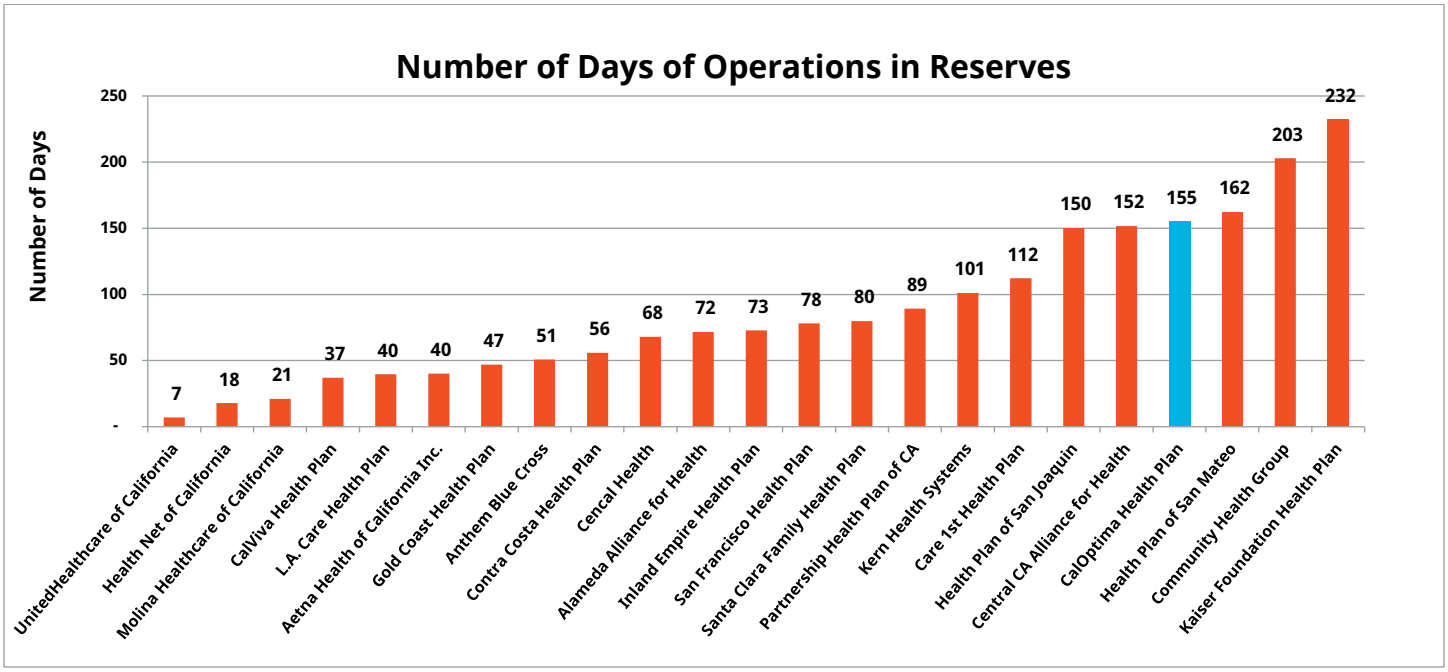
Net Asset Analysis

Exhibit 1: Resources Committed by the Board: $466.5M

Board-approved Initiatives	Status	Board Approved Amount	Spent Amount	Unspent Balance	Duration
Strategic Initiatives					
Homeless Health Initiative	In progress	$59.9	$38.4	$21.5	Multiple
Housing and Homelessness Incentive	In progress	52.7	11.9	40.8	Multiple
Digital Transformation Strategy (DTS)	In progress	100	8.5	91.5	FY 23 - FY 25
Intergovernmental Transfers (IGT)	In progress	111.7	52.6	59.1	Multiple
General Awareness and Brand Development	In progress	2.7	1.6	1.1	CY 2023
Subtotal		***$327.0***	***$113.0***	***$214.0***	
Quality/Population Health Management					
OneCare Member Health Incentives	Close to starting	1	0	1	CY 2023
Five-Year Hospital Quality Program	In progress	153.5	0	153.5	CY 2023 - CY 2027
Medi-Cal Annual Wellness Initiative	Close to starting	15	0	15	CY 2023
Skilled Nursing Facility Access Program	Close to starting	10	0	10	FY 24 - FY 26
In-Home Care Pilot Program with the UCI	In progress	2	0	2	CY 2023 - CY 2024
NAMI Orange County Peer Support Program	In progress	5	0	5	CY 2023 - CY 2027
Community Living and 2nd PACE Center	In progress	18	0	18	CY 2023
Member Health Needs Assessment	Close to starting	1	0	1	CY 2023
Subtotal		***$205.5***	***$0.0***	***$205.5***	
Grant Programs					
CalFresh Outreach Strategy	In progress	8	1	7	FY 22 - FY 23
Mind OC Grant (Orange)	Finished	1	1	0	One-time
Mind OC Grant (Irvine)	Finished	15	15	0	One-time
Coalition of OC Community Health Centers	In progress	50	10	40	FY 23 - FY 27
Subtotal		***$74.0***	***$27.0***	***$47.0***	
Total		**$606.5**	**$140.0**	**$466.5**	

Exhibit 2: Comparison to Other California Health Plans (as of December 31, 2022)

Days of Operations in Reserves (including Fixed Assets)



Data source: Local Health Plans of California analysis using DMHC data: https://wpso.dmhc.ca.gov/fe/search/

Reserve Level Requirements in Plan Policy

Health Plan	Policy	*Equivalent Days*
Community Health Group	4 months	*120 days*
Central CA Alliance for Health	3 months	*90 days*
Inland Empire Health Plan	60 days	*60 days*
Partnership HealthPlan of California	60 days	*60 days*
CalOptima Health	1.4 – 2.0 months	*42 – 60 days*

Data source: Parks, G. (2023). *CalOptima Health: It Has Accumulated Excessive Surplus Funds and Made Questionable Hiring Decisions* (Report 2022-112). California State Auditor. https://voiceofoc.org/wp-content/uploads/2023/05/CalOptima-Audit-Report.pdf

Exhibit 3: Board Designated Reserves Analysis: $579.9M

Reserve Name	Market Value (in millions)	*Avg Monthly Revenue*	Current Compliance Level	***Amount Required @ 1.4 Times***	***Amount Required @ 2.0 Times***	***Amount Required @ 3.0 Times***
Tier 1: Board Designated Reserve	$470.47					
Tier 2: TNE	$109.44					
Total:	**$579.91**	*$303.07*	**1.91**	***$424.30***	***$606.14***	***$909.21***
Increase from Current Amount:					*$26.23*	*$329.30*
Remaining Unallocated Resources:	*$463.70*				*$437.47*	*$134.40*

Policy #:	GA.3001
Title:	**Board-Designated Reserve Funds**
Department:	Finance
Section:	Not Applicable
CEO Approval:	Michael Schrader MS
Effective Date:	11/01/96
Last Review Date:	09/01/16
Last Revised Date:	09/01/16

I. PURPOSE

This policy establishes CalOptima's policy and procedure for the creation, maintenance, and utilization of reserve funds for the benefit of CalOptima's long-term financial viability.

II. POLICY

A. It shall be the goal of CalOptima to maintain Board-designated reserve funds of no less than one point four (1.4) months' consolidated capitation revenues and no more than two (2.0) months' consolidated capitation revenues. Additional goals for the creation of Board-designated reserve funds shall be approved by the CalOptima Board of Directors (Board), as deemed necessary by management and the Board.

B. Creation of Board-Designated Reserve Funds

1. Existing Reserves

   a. Working capital deficits shall be subtracted from reserves.

2. Creation of New Reserves

   a. Management shall transfer, from time to time, funds into Board-designated reserve funds no greater than the net available for reserves for any given Fiscal Year, plus additional funds if deemed appropriate.

   b. On a Fiscal Year-to-date basis, the net available for reserves is equal to the excess of capitation revenues, investment income, and other income over the combined medical and administrative costs for the same fiscal period. This amount shall be available for increases to the Board-designated reserve funds.

   c. For purposes of this policy, one (1) month's consolidated capitation revenues is calculated based on the average consolidated capitation revenue excluding special pass-through payments such as Quality Assurance Fees (QAF) and Intergovernmental transfers (IGT) or prior year rate adjustments implemented in the current year during the most recent twelve (12) month period for which all capitation payments have been received by CalOptima, and for which internally-prepared financial statements are available.

   d. CalOptima's Fiscal Year begins on July 1 of each year, and ends on June 30 of the following year.

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C. Purpose and Utilization of Existing Reserves

1. Board-designated reserve funds are created for the purposes of maintaining CalOptima reserve levels in compliance with State requirements, maintaining CalOptima's healthcare delivery system during short-term crises, and protecting CalOptima's long-term financial viability.

2. Utilization of existing reserves during a delay in capitation revenues from the State.

   a. In the event of a delay in CalOptima's receipt of capitation revenues from the State, and provided the Board-designated reserve funds level is within the range as set forth in Section II.A of this policy (Range). CalOptima staff is authorized to use the Board-designated reserve funds to provide up to two (2.0) months of continuous payments to Providers and vendors without the approval of the Board, provided that the reserve level remains within the range.

   b. If the delay in CalOptima's receipt of capitation revenues from the State exceeds two (2) months, or the amount of Board-designated reserve funds falls below the range set forth in Section III.A., CalOptima staff may propose actions to the Board to ensure financial stability for CalOptima and its Providers and vendors.

   c. In the event the amount of cash reserves approaches the minimum level required by the State, CalOptima may elect, with approval of the Board, to cease payments to Providers and vendors until such time as the State restores capitation revenue to CalOptima.

3. Except as authorized in Section II.C.2.a. of this policy, any withdrawals from Board-designated reserve funds shall be approved by the Board through the annual Budget process, or through a separate action approved by the Board at a regular or special meeting of the Board. The Budget is CalOptima's Board-approved annual operating Budget that incorporates net available for reserves.

4. The Board, through approval of a Board Action Request, may specifically designate all or a portion of Board-designated reserve funds for one (1) or more Special Purposes at any time. A Special Purpose is a specifically designated use, as determined solely by the Board, that best addresses a programmatic or financial need facing CalOptima. The Board may also remove or modify any or all such specific designations previously imposed through approval of a subsequent Board Action Request.

5. CalOptima management shall notify the Board of all uses of Board-designated reserve funds, regardless of prior approval requirements set forth in this policy.

6. On an annual basis, the Board may review this policy concurrently with the approval of the annual operating budget.

III. PROCEDURE

A. Transfers to or from Board-Designated Reserve Funds

1. Prior to the end of each month, CalOptima's Chief Financial Officer (CFO), Chief Executive Officer (CEO), or designee, shall instruct the Controller, or his or her designee, to transfer a

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specified dollar amount into or from CalOptima's Board-designated reserve funds (from or to CalOptima's operating funds). Said transfer shall be consistent with either the Board's approved Budget or a subsequently approved Board Action Request.

B. Financial Reporting with Respect to Board-Designated Reserve Funds

1. When reporting each month's financial results, the CFO, or his or her designee, shall routinely update the Board as to the status of Board-designated reserve funds. The status report shall be rendered on a quarterly basis, or more frequently as directed by the Board.

C. In accordance with Section II.C.4. of this policy, CalOptima management shall, upon its own initiative or the request of the Board, prepare and submit a Board Action Request to specifically designate, for one (1) or more Special Purposes, all or a portion of the Board-designated reserve funds. If the Board approves such Board Action Request, management shall so describe the specific designations of such funds on subsequent CalOptima balance sheets. The subsequent removal or modification of a previously approved specific designation of Board-designated reserve funds shall follow the same process as that utilized for creating the original designation. If the Board subsequently approves the removal or modification of a specific designation, management shall appropriately adjust future CalOptima balance sheets to properly account for such removal or modification.

D. In accordance with all applicable statutory and regulatory requirements, CalOptima shall, at all times, maintain a Board-designated reserve funds level no less than the minimum tangible net equity requirements established by the State.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

Not Applicable

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/03/15: Regular Meeting of the CalOptima Board of Directors
B. 06/06/13: Regular Meeting of the CalOptima Board of Directors
C. 03/01/12: Regular Meeting of the CalOptima Board of Directors
D. 06/06/00: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	11/01/1996	GA.3001	Board-Designated Reserve Funds	Administrative

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Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	06/2000	GA.3001	Board-Designated Reserve Funds	Administrative
Revised	06/01/2007	GA.3001	Board-Designated Reserve Funds	Administrative
Revised	03/01/2012	GA.3001	Board-Designated Reserve Funds	Administrative
Revised	06/06/2013	GA.3001	Board-Designated Reserve Funds	Administrative
Revised	12/03/2015	GA.3001	Board-Designated Reserve Funds	Administrative
Revised	09/01/2016	GA.3001	Board-Designated Reserve Funds	Administrative

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IX. GLOSSARY

Not Applicable

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Transplants Update

Board of Directors Meeting

June 1, 2023

Richard Lopez, M.D., Medical Director

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 Organ Transplants

Partnership with Centers of Excellence (COE)

- Expedite Referrals, Evaluation and Treatment
- Encourage Communication Between Providers
- Educate Community Providers
- Monitor and Track CalOptima Health Patients
- Improve Outcomes

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CalOptima Health

Current COE for CalOptima Health

(Current Contracts)

- **University of California, Irvine (UCI):** Bone Marrow Transplant (BMT), Kidney, Pancreas, Simultaneous Kidney Pancreas Transplant (SKP)
- **City of Hope (COH):** BMT
- **Children's Hospital Los Angeles (CHLA):** Heart, Liver, Kidney, Multiorgan

(Work in Progress)

- **University of California, San Diego (UCSD): Heart, Lung, Liver, Kidney, Multiorgan**
- **Rady Children's**

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CalOptima Health

Partnership with UCSD

Benefits:

- Separate Organ Procurement Organization
- Shorter Waiting Times for Organ Transplant
- Excellent Outcomes
- Multiorgan Transplants Available
- Affiliation with Rady Children's Hospital

Challenges:

- Housing and Transportation
- Home Health and Skilled Nursing Services

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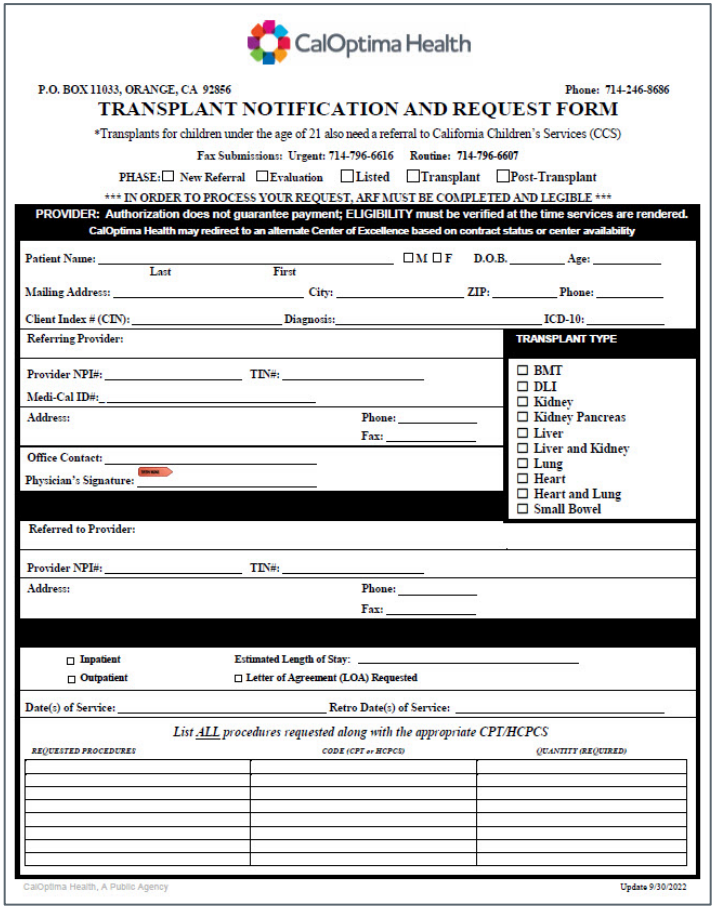
CalOptima Health

Dedicated for Transplant

- Medical Director: Dr. Richard Lopez
- Fax: 714-796-6616
- Transplant notification and request form (current)



CalOptima Health

P.O. BOX 11033, ORANGE, CA 92856 Phone: 714-246-8686

TRANSPLANT NOTIFICATION AND REQUEST FORM

*Transplants for children under the age of 21 also need a referral to California Children's Services (CCS)

Fax Submissions: Urgent: 714-796-6616 Routine: 714-796-6607

PHASE: ☐ New Referral ☐ Evaluation ☐ Listed ☐ Transplant ☐ Post-Transplant

*** IN ORDER TO PROCESS YOUR REQUEST, ARF MUST BE COMPLETED AND LEGIBLE ***

PROVIDER: Authorization does not guarantee payment; ELIGIBILITY must be verified at the time services are rendered.
CalOptima Health may redirect to an alternate Center of Excellence based on contract status or center availability

Patient Name: _____ (Last) _____ (First) ☐M ☐F D.O.B. _____ Age: _____

Mailing Address: _____ City: _____ ZIP: _____ Phone: _____

Client Index # (CIN): _____ Diagnosis: _____ ICD-10: _____

Referring Provider:

Provider NPI#: _____ TIN#: _____

Medi-Cal ID#: _____

Address: Phone: _____ Fax: _____

Office Contact: _____

Physician's Signature: _____

TRANSPLANT TYPE

☐ BMT
☐ DLI
☐ Kidney
☐ Kidney Pancreas
☐ Liver
☐ Liver and Kidney
☐ Lung
☐ Heart
☐ Heart and Lung
☐ Small Bowel

Referred to Provider:

Provider NPI#: _____ TIN#: _____

Address: Phone: _____ Fax: _____

☐ Inpatient ☐ Outpatient Estimated Length of Stay: _____ ☐ Letter of Agreement (LOA) Requested

Date(s) of Service: _____ Retro Date(s) of Service: _____

List ALL procedures requested along with the appropriate CPT/HCPCS

REQUESTED PROCEDURES	CODE (CPT or HCPCS)	QUANTITY (REQUIRED)

CalOptima Health, A Public Agency Update 9/30/2022

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CalOptima Health

Questions

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MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

May 4, 2023

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on May 4, 2023, 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 (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. Chair Corwin called the meeting to order at 2:01 p.m., and Director Chau led the Pledge of Allegiance.

The Clerk noted for the record that Director Shivers was participating remotely for "Just Cause", and Chair Corwin noted that under the Brown Act, as amended, a Board Member can only use "Just Cause" up to two times per calendar year and verified that Director Shivers did not have anyone over the age of 18 in the room with her today.

The Clerk also noted for the record that Agenda Items 13 and 14 were being continued due to lack of a quorum.

ROLL CALL

Members Present: Clayton Corwin, Chair; Blair Contratto, Vice Chair; Isabel Becerra; Supervisor Doug Chaffee; Clayton Chau, M.D. (non-voting); José Mayorga M.D.; Supervisor Vicente Sarmiento; Nancy Shivers

(All Board Members in attendance participated in person except Director Shivers, who participated remotely under Just Cause, using her second and last use of two under Just Cause as a result of AB 2449)

Members Absent: Trieu Tran, 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

PRESENTATIONS/INTRODUCTIONS

1. Homeless Health Incentive Program Grantee Presentation

Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, noted that CalOptima Health awarded nearly $30 million dollars in community grants in March of this year as part of its Homeless Health Incentive Program (HHIP). These initial investments are being used to have a greater impact on the health of CalOptima Health's unhoused members. Ms. Bruno-Nelson asked the Board to step down from the dais and present the checks to each of the following grantees:

American Family Housing. CalOptima Health awarded a $2.9 million capital grant to support the project in Midway City area that brings online 111 permanent supportive and affordable housing units in a residential community.

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Korean Community Services. CalOptima Health awarded a $2.5 million capital grant to support the project in Garden Grove to develop 100 new units of permanent supportive housing.

Friendship Shelter. CalOptima Health awarded a $3.8 million capital grant to support the project to acquire and renovate a motel in the San Clemente affordable housing overlay zone to provide permanent supportive housing to chronically homeless individuals.

Salvation Army. CalOptima Health awarded a $4.1 million capital grant to support the project of bringing online the Center of Hope permanent supportive housing units to be opened this summer. The units will house 70 individuals experiencing chronic homelessness connected through the County's Coordinated Entry System.

Thomas House Family Shelter. CalOptima Health awarded a $254,000 capacity building grant to support two new positions on its staff, a housing navigator, and a career development specialist. The addition of these two key positions will enable Thomas House to enhance and expand services to families and children in Orange County.

WISEPlace. CalOptima Health awarded a $315,000 equity grant for the work providing a safe, low barrier, and culturally relevant support services to unaccompanied women experiencing homelessness before transitioning to supportive housing.

Michael Hunn, Chief Executive Officer (CEO), presented Director Clayton Chau with a recognition award for his service on the Board and to CalOptima Health's members. Director Chau spearheaded Orange County's robust and equitable COVID-19 response to the pandemic. Mr. Hunn noted that Director Chau is an effective leader, caring human being, and a fine physician. He added that it has been a privilege to have Dr. Chau on the CalOptima Health Board and as the Director of the Orange County Health Care Agency Dr. Chau has been a wealth of information and knowledge.

Chair Corwin thanked Director Chau on behalf of the Board for his level of professionalism, coupled with compassion and expertise during his service on the CalOptima Health Board.

MANAGEMENT REPORTS

2. Chief Executive Officer Report

Mr. Hunn, CEO, started his report by acknowledging all the community organizations in the room today and congratulating them for the work that they do in Orange County. He noted that CalOptima Health as a Medi-Cal health plan, could not affect true community health without the partnerships and collaborations with the leaders that are in the room today. Mr. Hunn thanked each of the organizations and added that it is a privilege to share these important funds. He also thanked Ms. Bruno-Nelson for her work with the community support organizations and thanked the Board for its approval of the initiatives for the community and CalOptima Health's members.

Mr. Hunn provided an update on the Street Medicine Program. The program started on April 3, 2023, and the Street Medicine van has been on the streets for 25 days, contacting 90 individuals through canvassing the area. Out of those 90 individuals, 34 individuals have signed up for medical services and housing navigation. Mr. Hunn emphasized that the Street Medicine Program is a collaborative effort between many organizations including Healthcare in Action, City of Garden Grove, Garden Grove Police Department, Orange County Fire Authority, Orange County Families Together, Health Care Agency, Be

Well OC, and others. He shared that the Garden Grove Police had encountered a gentleman living in a tent under the 22 Freeway who was quite frail and in obvious need of medical attention. Despite the police officers' efforts, the gentleman would not leave his tent under the freeway. After four days of people from the various organizations mentioned above reaching out and building a rapport with the gentleman, they were able to relocate him to a skilled nursing home to assist with his medical needs and will work on housing once he is stabilized. Mr. Hunn thanked the Board for its approval of the various initiatives to make a difference in Orange County's most vulnerable population.

Mr. Hunn welcomed CalOptima Health's new Medical Director, Dr. Steven Arabo, who will be responsible for OneCare members. Mr. Hunn also noted that CalOptima Health is making changes to its medically tailored meals policy and effective May 5, 2023, eligible CalOptima Health members will be able to receive a maximum of 24 weeks of medically tailored meals.

Mr. Hunn reviewed the Fast Facts data, noting that currently CalOptima Health serves 978,089 individuals with membership continuing to increase monthly. CalOptima Health spends 93.0% of every dollar on medical care, and 4.4% is the overhead cost to administer the program.

CalOptima Health's Board-designated reserves are $577.5 million; its capital assets are $67.1 million; its resources committed by the Board are $441.4 million; and its unallocated and unassigned resources are $455.7 million. Mr. Hunn noted that CalOptima Health's total net assets are currently $1.5 billion.

Mr. Hunn also reviewed the CalOptima Health personnel data and noted that there are 1,460 employees with a vacancy/turnover rate of about 8.30% as of the April 8, 2023, pay period. CalOptima Health's vacancy/turnover target is to be at less than 12.5% to 15% at any given time.

Mr. Hunn reviewed the provider data, noting that CalOptima Health has over 9,500 providers, 1,286 primary care providers, and 8,230 specialists; 565 pharmacies; 45 acute and rehab hospitals; 34 community health centers; and 100 long term care facilities.

Mr. Hunn reviewed CalOptima Health's treatment authorizations, noting that this data is as of February 28, 2023. For urgent inpatient treatment authorizations, the average approval is within 10.62 hours; the state-mandated response is 72 hours. For urgent prior authorizations, the average approval is within 15.06 hours; the state-mandated response is 72 hours. And for routine prior authorizations, the average approval is 1.74 days; the state-mandated response is 5 days. Mr. Hunn noted that there are not enough physicians and specialists in Orange County, partly because many are at retirement age. He added he is hopeful that there will be a better pipeline of physicians in the future.

Mr. Hunn provided an update on the California State Audit. The audit was requested back in June 2022 by the Joint Legislative Action Committee. Mr. Hunn began by thanking the California state auditors, noting that they were professional, collaborative, and communicative. Mr. Hunn also thanked Assemblywoman Sharon Quirk-Silva for her input with regard to the audit. He also appreciated the input from key stakeholders and staff. The audit lasted 9.5 months, and it looked back from 2014 through June 2022. Mr. Hunn noted the audit was pretty extensive, and a lot of documents were put together in response to the audit. He thanked Chief Compliance Officer, John Tanner; his staff; Chief Financial Officer, Nancy Huang; Executive Director, Medi-Cal/CalAIM, Kelly Bruno-Nelson for all of the reports around homelessness and the CalAIM work; and Chief Operating Officer, Yunkyung Kim, for all of the operational overview issues that need to be reviewed when going through an audit of this magnitude. Mr.

Hunn noted that CalOptima Health is audited on a very consistent basis by its regulators, the Department of Health Care Services (DHCS), the Centers for Medicaid & Medicare Services (CMS), and the Department of Managed Health Care. He also noted that CalOptima Health is audited regularly by the National Committee for Quality Assurance, which determines quality ratings for health plans. CalOptima Health is audited quite a bit, and this latest audit was little bit longer than most audits. It lasted nine and half months, and the state budgeted 2,394 auditor hours, with an established budget of $323,190. Mr. Hunn commented that the state may have exceeded its budget, and that on the CalOptima Health side, staff spent a significant amount of time, likely triple the number of hours and effort, in response to the audit.

Mr. Hunn reviewed in detail each of the findings noted in the California State Audit and CalOptima Health's response to each of the findings. Many of the findings had already been addressed before the audit was completed. For finding number three, Mr. Hunn noted that CalOptima Health acknowledges that in April 2020, the then Board may have failed to observe provisions in Government Code section 1090 by appointing a sitting Board member to serve as CalOptima Health's interim CEO as a result of previous in-house legal counsel concurring on the action and the Board relying on such concurrence. He also noted that none of the Board members involved in that action are on the current Board and the involved staff are no longer employed by CalOptima Health. Mr. Hunn again thanked the California State Auditors, Assemblywoman Sharon Quirk-Silva, and CalOptima Health staff, stakeholders, and the Board for their support during this extensive audit.

Chair Corwin thanked Mr. Hunn for the very complete and clear summary of the auditor's findings and CalOptima Health's responses. Chair Corwin also thanked everyone involved at all levels in responding to the audit. He noted that it is an arduous task, covering nine years, and there is a lot of work to be done. Chair Corwin further stated that hopefully the results, as with any audit, allow CalOptima Health to continue to improve as an organization, and he noted he is sure it will. Chair Corwin noted that CalOptima Health had several actions already in play and is taking steps to address most of what was raised in the report. He also noted that there is one issue he wanted to address and that is the April 2020 hiring by a previous Board of the interim CEO and that the finding may have violated state law. Chair Corwin announced the formation of an Ad Hoc Committee comprised of Vice Chair Contratto and himself to work with counsel and review that issue and report back to the Board.

Supervisor Chaffee commented that he appreciated the audit but noted that it is really a snapshot in time of the past. He added that CalOptima Health has a mission, and it is going to stay on the mission and continue to serve the people in Orange County. Supervisor Chaffee also noted that if the audit had covered through to current day, the auditors would have found that the items of concern no longer exist. He commented that CalOptima Health has great staff and thanked everyone for continuing to serve its mission.

Supervisor Sarmiento thanked staff for preparing the thoughtful responses to the questions that were asked during the audit. He noted that he is a new Board member on this Board and does not have the history that many of his colleagues have on this Board. Going forward, the Board owns the decisions that are going to be made, and it needs to be thoughtful as it moves forward. Supervisor Sarmiento added that he is encouraged by the corrective actions being taken as a result of the audit findings. He mentioned one of the findings having to do with CalOptima Health having a surplus of reserves and said that is something that the Board will need to look at and determine what those reserves should be in order to ensure the agency is financially viable. Supervisor Sarmiento noted there should be a distinction between

holding funds unnecessarily and spending them wisely. He also added that staff has already taken action to correct many of the findings and he looks forward to working with the Board and staff to ensure that CalOptima Health funds are spent in a responsible manner. Supervisor Sarmiento thanked staff for all the work that went into responding to the audit.

3. Brand Awareness Campaign

Deanne Thompson, Executive Director, Marketing and Communications, presented the details of CalOptima Health's new brand awareness campaign. Ms. Thompson noted that last fall CalOptima Health introduced the new brand, with a new name and a new logo, communicating a connection to its diverse community, inspiring joy, and celebration. CalOptima Health then embarked on a brand discovery process to develop an understanding of its brand and to position the organization as serving complex needs of the most vulnerable members of its community. The brand discovery process revealed some key discoveries. First, CalOptima Health has unmatched resources to meet the needs of its members and the broader Orange County community. Second, CalOptima Health is making progress in addressing challenges, including low target audience awareness and provider dissatisfaction with CalOptima Health processes and reimbursement. Ms. Thompson reviewed the various brand campaigns that will be displayed at the John Wayne airport, the Brea Mall, and OCTA bus advertisements. In addition, CalOptima Health will also advertise in threshold languages and also run television ads, radio ads and newspaper ads. She also presented the CalOptima Health brand anthem that will be shown and heard on television and radio.

4. Fiscal Year 2023-2024 Budget Planning

Nancy Huang, Chief Financial Officer, presented a budget preview for FY 2023-2024. Ms. Huang reviewed three key items: Upcoming budget challenges, program performance forecast, and a preliminary enrollment forecast. She noted that the state is projecting a $22.5 billion deficit, which was mainly driven by a decrease in personal income tax revenue. Governor Newsom is expected to release the May Revised Budget, and it is expected that the state budget deficit may trigger cuts to Medi-Cal plans. She noted that 90% of CalOptima Health's funding comes directly from DHCS, so cuts to Medi-Cal will have a direct impact. Ms. Huang also noted that with the end of the public health emergency CalOptima Health will start to see decreases in membership in July 2023 through June 2024, and is projecting a reduction of approximately 190,000 members. Another impact to CalOptima Health's budget is the transition of 55,000 Kaiser members effective January 1, 2024. She also explained that even with the potential membership gain from the state's Medi-Cal adult expansion of undocumented adults between ages 26-49, CalOptima Health is still projecting a net decrease of 200,000 Medi-Cal members. She noted that the future forecast included enrollment decreases for FY 2024-2025 and also noted that state's regional rate setting in Calendar Year 2025 may result in additional rate cuts to CalOptima Health. The Medi-Cal line of business is forecasted to have a modest surplus; OneCare is forecasting a budget deficit; PACE is forecasting a small surplus. The preliminary membership projection is a high of 1,009,649 members in June 2023 to a projected low of 810,045 members in June 2024. Ms. Huang noted that the full FY2023-24 budget will be presented at the June Board meeting for consideration.

PUBLIC COMMENTS

There were seven general public comments related to the Homeless Health Incentive Program grants:

1. Shakoya Green Long, Executive Director, Thomas House Family Shelter
2. Benjamin Hurst, The Salvation Army
3. David Duran, Housing is a Human Right OC
4. Elizabeth Casillas, American Family Housing

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5. Steve Renahan, American Family Housing
6. Milo Peinemann, American Family Housing
7. Dawn Price, Friendship Shelter

There were five public comments regarding Agenda Item 16:
1. Mikyong Kim-Goh, California State University Fullerton, MSW Program
2. Marcella Mendez, California State University Fullerton, MSW Program
3. Duan Tran, California State University Fullerton, MSW Program
4. Gavin Sweeney, California State University Fullerton, MSW Program
5. Anna Chavez Garcia, California State University Fullerton, MSW Program

CONSENT CALENDAR

5. Minutes

a. Approve Minutes of the April 6, 2023 Regular Meeting of the CalOptima Health Board of Directors

6. Authorize and Direct Execution of an Amendment to CalOptima Health's Primary Agreement with the California Department of Health Care Services

7. Authorize and Direct Execution of Amendment 09 to Agreement 16-93274 (Care Coordination Agreement) with the California Department of Health Care Services in Order to Continue Operation of the Dual Eligible Special Needs Plan OneCare Program

8. Appointment to the CalOptima Health Board of Directors' Member Advisory Committee

9. Adopt Resolution No. 23-0504-02 Approving and Adopting Updated and New CalOptima Health Human Resources Policies

Director Mayorga pulled this item for discussion.

10. Approve New CalOptima Health Policy AA.1400p: Grants Management

11. Receive and File:

a. March 2023 Financial Summary
b. Compliance Report
c. Federal and State Legislative Advocates Reports
d. CalOptima Community Outreach and Program Summary

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 5 through 11, minus Agenda Item 9 as presented. (Motion carried 7-0-0; Director Tran absent)***

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9. Adopt Resolution No. 23-0504-02 Approving and Adopting Updated and New CalOptima Health Human Resources Policies

Mr. Hunn introduced the item.

Director Mayorga commented that he would like to get a better understanding of the new policy, the recruitment section in particular, and questioned why the CEO was excluded from this policy. He noted that it would be helpful for the public to understand the rationale.

James Novello, Outside General Counsel, responded that per Article 9 of the CalOptima Health Bylaws, the specific hiring and employment guidelines regarding the CEO, the Bylaws entrust the Board with all things related to the employment of the CEO, including qualifications, searching, performance evaluations, and anything else related to the CEO's performance. If the Board chooses, it could create an Ad Hoc Committee to look at other agencies' best practices.

Supervisor Sarmiento added that he thought it would be a good idea to form an Ad Hoc Committee to look at the structure and best practices as it relates to CEO recruitment and qualifications since it was mentioned in the audit. Mr. Novello concurred with Supervisor Sarmiento and offered his assistance.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors Adopted Resolution No. 23-0504-02 approving: 1.) Updated CalOptima Health policies: a.) GA.8031: Internship Program; b.) GA.8032: Employee Dress Code; c.) GA.8037: Leave of Absence; d.) GA.8039: Pregnancy Disability Leave of Absence and Lactation Accommodation; e.) GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence; f.) GA.8042: Supplemental Compensation and Attachments A-B; and g.) GA.8059: Attendance and Timekeeping; 2.) New CalOptima Health policy: a.) GA.8060 Recruitment, Selection, and Hiring. (Motion carried 7-0-0; Director Tran absent)***

REPORTS/DISCUSSION ITEMS

12. Adopt Board Resolution No. 23-0504-03, Proclaiming the Resumption of Medi-Cal Redeterminations as a Serious Risk to Continued Health Care Coverage and Encouraging All Orange County Stakeholders to Support Medi-Cal Renewal Efforts

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors adopted Board Resolution No. 23-0504-03, proclaiming the resumption of Medi-Cal redeterminations as a serious risk to continued health care coverage and encouraging all Orange County stakeholders to support Medi-Cal renewal efforts. (Motion carried 7-0-0; Director Tran absent absent)***

13. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Certain Health Networks and Contracted Providers Except Community Clinics, to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

This item was continued to a future meeting.

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14. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Community Clinics to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency
This item was continued to a future meeting.

15. Approve Actions Related to the Garden Grove Street Medicine Support Center

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Directed the Chief Executive Officer to develop a proposal to include a Street Medicine Support Center Component to the existing Board-approved Street Medicine Initiative; and 2.) Authorized the Chief Executive Officer to explore real estate options in the City of Garden Grove for a potential location to serve as a Street Medicine Support Center. (Motion carried 7-0-0; Director Tran absent)***

16. Approve Actions Related to Establishing a Stipend Program for Master of Social Work Students Attending California State University, Fullerton
Ms. Kim introduced the item.

Director Chau recommended that the Board consider increasing the dollar amount given the number of students CalOptima Health is hoping to support that enroll in the California State University Fullerton, Master of Social Work program.

Director Chau noted for the record that even though he is not a voting member on the CalOptima Health Board, that he does sit on the Advisory Board for the School of Social Work at Cal State Fullerton.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Directed the Chief Executive Officer, or designee, to develop and execute a grant agreement with California State University, Fullerton to administer a CalOptima Health Master of Social Work stipend program no earlier than September 1, 2023, for a five-year term; 2.) Authorized expenditures in an amount up to $5 million from existing reserves to fund the stipend program; and 3.) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose. (Motion carried 7-0-0; Director Tran absent)***

17. Approve Actions Related to the Student Behavioral Health Incentive Program Funding Strategy
Ms. Kim introduced the item.

Director Mayorga commented that as a family physician he is pleased to see that CalOptima Health is investing in the children in Orange County. As a Board member he appreciates how wisely CalOptima Health continues to invest in not only the adult population but also in the children.

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors: 1.) Authorized 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.) Authorized 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.) Authorized funding for and distribution of incentive payment prior to CalOptima Health's receipt of SBHIP program incentive dollars from the State of California. (Motion carried 7-0-0; Director Tran absent)

18. Adopt Resolution No. 23-0504-01 Approving and Adopting Updated CalOptima Health Human Resources Policies; Authorize the Chief Executive Officer to Implement Cost-of-Living Adjustments, Appropriation of Funds, and Authorization of Unbudgeted Expenditures

The Clerk noted for the record that staff has amended this motion and read the amended motion into the record.

Director Mayorga commented that the executive line was not adjusted in the salary schedule for this item.

Mr. Hunn responded that in looking at the executive level salary ranges, given the majority of the executives are not at the midpoint, there is no need to raise the ceiling of their salary ranges.

Vice Chair Contratto commented on the importance of this initiative and the work that Brigette Hoey and her team are doing to keep CalOptima Health's salary ranges competitive. This is a direct correlation to the reduction in turnover that the agency has experienced in the last couple of years.

Supervisor Sarmiento commented that Orange County is a very high-cost area to live in and CalOptima Health wants to make sure it is competitive. He also noted that salaries should be based on merit and performance. Supervisor Sarmiento also added he wanted to make sure the amended language is reflected on the record.

Action: ***On motion of Vice Chair Contratto, seconded and carried, the Board of Directors: 1. Adopted Resolution No. 23-0504-01 Approving Updated CalOptima Health Policies: a.) GA.8012: Conflicts of Interest and Attachments A-C; and b.) GA.8058: Salary Schedule and Attachment A – CalOptima Health Annual Base Salary Schedule (Attachment A) and staff has amended this motion to exclude executive level positions and these changes will be reflected in Attachment A in the archived materials; 2.) Authorized the Chief Executive Officer (CEO) to implement two percent (2%) salary increases as cost-of-living adjustments (COLAs) for all employees, except executive level positions; and 3.) Appropriated funds and authorized unbudgeted expenditures in an amount up to $726,000 from salary savings to fund COLAs and job title pay grade changes through June 30, 2023. (Motion carried 7-0-0; Director Tran absent)*** *Rev. 05/04/2023*

19. Authorize a Letter of Support for 360 PACE to Offer a Program of All Inclusive Care for the Elderly in Orange County

Action: ***On motion of Vice Chair Contratto, seconded and carried, the Board of Directors: Authorized the Chief Executive Officer to provide 360 PACE***

with a letter of support to operate a Program of All Inclusive Care for the Elderly (PACE) program in select zip codes in Orange County, independent of CalOptima Health. (Motion carried 7-0-0; Director Tran absent)

20. Authorize the Chief Executive Officer (CEO) to Submit OneCare Bid for Calendar Year 2024 and Execute Contracts with the Centers for Medicare & Medicaid Services and the California Department of Health Care Services; Authorize the CEO to Amend/Execute OneCare Health Network Contracts and Take Other Actions as Necessary to Implement ***(to Follow Closed Session)***

21. Member Advisory Committee and Provider Advisory Committee Update
Maura Byron, chair of the Member Advisory Committee (MAC) provided an update on behalf of both the MAC and the Provider Advisory Committee from their recent meeting on April 13, 2023.

CLOSED SESSION
The Board adjourned to Closed Session at 4:55 p.m.: CS-1. CONFERENCE WITH REAL PROPERTY NEGOTIATORS Pursuant to Government Code Section 54956.8, Under Negotiation: Price and terms of payments, Property: 14851 Yorba Street & 165 N. Myrtle Avenue, Tustin, CA 92780, Agency Negotiator: David Kluth, John Scruggs, and Mai Hu, Newmark Knight Frank, Negotiating Parties: Yorba Myrtle LLC; CS-2. CONFERENCE WITH REAL PROPERTY NEGOTIATORS Pursuant to Government Code Section 54956.8, Under Negotiation: Price and terms of payments, Property: 7900 Garden Grove Avenue, Garden Grove, CA 92841, Agency Negotiators: David Kluth, and Mai Hu, Newmark Knight Frank, Negotiating Parties: Lvt, Inc.; CS-3. Pursuant to Government Code section 54956.87, subdivision (b) HEALTH PLAN TRADE SECRETS: OneCare

The Board returned to Open Session at 5:24 p.m. and the Clerk reestablished a quorum.

ROLL CALL
Members Present: Clayton Corwin, Chair; Blair Contratto, Vice Chair; Isabel Becerra; Clayton Chau, M.D. (non-voting); Supervisor Vicente Sarmiento; Nancy Shivers

(All Board Members in attendance participated in person except Director Shivers, who participated remotely under Just Cause, using her second and last use of two under Just Cause as a result of AB 2449)

Members Absent: Supervisor Doug Chaffee; José Mayorga M.D.; Trieu Tran, M.D.

There were no reportable actions taken in closed session.

20. Authorize the Chief Executive Officer (CEO) to Submit OneCare Bid for Calendar Year 2024 and Execute Contracts with the Centers for Medicare & Medicaid Services and the California Department of Health Care Services; Authorize the CEO to Amend/Execute OneCare Health Network Contracts and Take Other Actions as Necessary to Implement

Action: ***On motion of Vice Chair Contratto, seconded and carried, the Board of Directors: Authorize the Chief Executive Officer (CEO) to Submit OneCare Bid for Calendar Year 2024 and Execute Contracts with the Centers for Medicare &***

Medicaid Services and the California Department of Health Care Services; Authorize the CEO to Amend/Execute OneCare Health Network Contracts and Take Other Actions as Necessary to Implement (Motion carried 5-0-0; Supervisor Chaffee, Directors Mayorga and Tran absent)

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

There were no Board member comments.

ADJOURNMENT

Hearing no further business, Chair Corwin adjourned the meeting at 5:26 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: June 1, 2023

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

March 9, 2023

A Special Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee (FAC) was held on March 9, 2023, 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 (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023.

Chair Isabel Becerra called the meeting to order at 3:08 p.m., and Director Contratto led the Pledge of Allegiance.

ROLL CALL

Members Present: Isabel Becerra, Chair; Blair Contratto; Clayton Corwin (All members participated in person)

Members Absent: None

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

MANAGEMENT REPORTS

1. Chief Financial Officer Report

Nancy Huang, Chief Financial Officer, provided two updates from her Chief Financial Officer Report. The first update was regarding the Medi-Cal eligibility redetermination, which will resume in April 2023 and continue through May 2024. The eligibility redetermination will impact CalOptima Health's revenue and medical expenses. Staff is evaluating the budget impact and will bring an updated forecast on the impact to the Fiscal Year (FY) 2023-24 budget. The second update was regarding the health network capitation rates rebasing efforts. Ms. Huang noted that CalOptima Health has retained Milliman, an actuarial consulting firm, to review the capitation rates and help set actuarially sound rates for its health networks. She added that the preliminary results were shared at the February 2023 health network forum. In aggregate, CalOptima Health anticipates a 2.9% base rate increase for the Medi-Cal line of business, effective beginning July 2023. Ms. Huang noted that the results will be shared at the May FAC meeting and then presented at the June Board of Directors (Board) meeting for final approval.

Director Contratto asked if CalOptima Health had received any feedback from the health networks regarding the 2.9% base rate increase. Ms. Huang responded that the health network feedback fell into two categories. First, the health networks wanted to understand the source data, the timeframe of the encounter data, and that the rebasing considered pre-COVID-19, during COVID-19, and post-COVID-19 data. The

second category of responses were related to data accuracy and how data is re-evaluated for certain benefits that count towards rebasing, while other benefits are carved out of rebasing. Ms. Huang used the maternity kick reimbursement as an example, noting that in the current process, the majority of the maternity reimbursement had been included as part of the per member per month base rates. Starting in July 2023, CalOptima Health will follow the same methodology as the Department of Health Care Services (DHCS). At the state level, DHCS uses the maternity kick payment as part of the delivery, which makes logical sense for maternity kick payments.

Director Corwin asked if any of the feedback from the health networks would change staff's recommendations regarding rebasing. Ms. Huang responded that none of CalOptima Health's assumptions have been identified as being incorrect or out of line with the rebasing efforts, so at this time, no changes are needed.

INVESTMENT ADVISORY COMMITTEE UPDATE

2. Treasurer's Report

Ms. Huang presented the Treasurer's Report for the period of October 1, 2022, through December 31, 2022. The portfolio totaled approximately $2.6 billion as of December 31, 2022. Of this amount, $2 billion was in CalOptima Health's operating account, and $568 million was included in CalOptima Health's Board-designated reserves. 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.

Director Corwin asked when does CalOptima Health transfer dollars from the various reserve accounts to a different account based upon Board action. Director Corwin provided a few examples, which included the recently approved Board action that allocated $150 million dollars from reserves for a five-year program of performance incentives for hospital providers. Ms. Huang responded that those dollars are still included in Board-designated reserves until the dollars are expended. She noted that this practice is in alignment with the Generally Accepted Accounting Principles (GAAP); however, she added that staff track the various allocations by using a net asset report to ensure CalOptima Health does not go over what the Board authorized. Ms. Huang further stated that she could include this report going forward.

Director Contratto recommended that staff create a visual for the Board that clearly shows the dollars allocated out of reserves by the Board, and the purpose for each allocation. She asked that the visual be color coded to make it easier for the Board and members of the public to review. Director Contratto also noted that this will be helpful for transparency purposes.

Michael Hunn, Chief Executive Officer, responded to the comments from Directors Corwin and Contratto by providing background on how CalOptima Health's financial data is reported and why it is reported in this manner. Mr. Hunn commented that staff is committed to providing an easy-to-understand graphic that provides more detail on the dollars allocated out of reserves by the Board.

PUBLIC COMMENTS

There were no requests for public comment.

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CONSENT CALENDAR

3. Approve the Minutes of the November 17, 2022, Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee and Receive and File Minutes of the October 24, 2022 Regular Meeting of the CalOptima Health Board of Directors' Investment Advisory Committee

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

The following items were accepted as presented.

4. December 2022 Financial Summary

5. CalOptima Information Technology Services Security Update

6. Quarterly Operating and Capital Budget Update

7. Quarterly Reports to the Finance and Audit Committee
   a. Shared Risk Pool Performance
   b. Whole-Child Model Financial Report
   c. Enhanced Care Management Financial Report
   d. Reinsurance Report
   e. Health Network Financial Report
   f. Contingency Contract Report

COMMITTEE MEMBER COMMENTS

Director Contratto thanked staff for how well the organization is performing, being mindful of public dollars.

Chair Becerra noted that she is happy to see that CalOptima Health is helping the Orange County community with additional funding for members, providers, and community-based organizations.

Mr. Hunn thanked the FAC members for their comments and noted that from July 2022 to present, with support from the Board and its committees, CalOptima Health has allocated $462.5 million dollars to serving the community and its members. He added that CalOptima Health has been purposeful in planning to utilize the designated unallocated reserves for various specific projects, programs and services. Mr. Hunn thanked the FAC, noting he looks forward to working with committee members and the Board to create a more formal process for spending undesignated reserves in service to the CalOptima Health mission and its members.

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Hearing no further business, FAC Chair Becerra adjourned the meeting at 3:40 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: May 22, 2023

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

5. Authorize and Direct Execution of Amendments to CalOptima Health's Primary Agreement with the California Department of Health Care Services Related to Rate Changes

Contact

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

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an amendment(s) to the Primary Agreement between the California Department of Health Care Services and CalOptima Health related to rate changes.

Background

As a County Organized Health System (COHS), CalOptima Health contracts with the California Department of Health Care Services (DHCS) to provide health care services to Medi-Cal beneficiaries in Orange County. In December 2016, CalOptima Health entered into a new four (4)-year agreement with the DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 62, which extends the Primary Agreement to December 31, 2023. *See,* Attachment 1_ Appendix summary of amendments to Primary Agreements with DHCS. The Primary Agreement contains, among other terms and conditions, the payment rates CalOptima Health receives from DHCS to provide health care services.

Discussion

Updated Calendar Year (CY) 2022 Rates

On May 8, 2023, DHCS provided CalOptima Health with updated Calendar Year (CY) 2022 capitation rates. Staff received authority during the March 2022 meeting of the CalOptima Health Board of Directors to incorporate the previous final version of the CY 2022 rates into CalOptima Health's Primary Agreement with the DHCS. *See*, Attachment 2_CY 2022 Rates March 2022.

DHCS noted that these rates will be further updated in the third quarter of 2023 to include the budget neutral split in rates for the unsatisfactory immigration status (UIS) and satisfactory immigration status (SIS) populations. The details of CalOptima Health's updated CY 2022 rates are outlined below.

Programmatic Changes

- Implementation of an additional 10% unit cost increase in accordance with the COVID-19 Public Health Emergency (PHE) fee schedule increase for long–term care (LTC) facilities (including hospice room and board).

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    - The prior CY 2022 rates assumed that the PHE would end prior to the rating period; therefore, the additional fee schedule increase was not reflected in the prior version of the rates.
- Implementation of Assembly Bill 97 buybacks for select providers and the partial duals mandatory managed care transition.
    - These programmatic changes were made effective in CY 2022 after the original rate development.
- Delayed implementation date of the dyadic health care services and doula programmatic changes until January 1, 2023. Therefore, these program changes are not applied in the updated version of the CY 2022 rates.

Population Acuity

- The population acuity adjustment was updated to account for the halt in disenrollment during the PHE.
    - At the time of the original development of the CY 2022 capitation rates, the PHE end date was assumed to be December 2021 with the disenrollment occurring during the rating period.

Enrollment

- CY 2022 enrollment counts now display actual membership counts observed from January 2022–December 2022.
    - The enrollment counts were updated to account for the halt in disenrollment during the PHE, producing significant deviations from the original projected enrollment.
    - The new enrollment was used to recalculate final budget neutral managed care organization (MCO) risk scores, county average rates, and regional rates for applicable MCOs (in addition to the Hospital Quality Assurance Fee (HQAF) and MCO tax calculations noted below).

Add-Ons

- The Major Organ Transplant (MOT) add-on was updated to reflect finalized University of California (UC) case rates.
- The HQAF add-on was updated to account for the halt in disenrollment during the PHE.
    - As noted above, significant deviations from projected enrollment were observed due to the continuation of the PHE past the assumed termination date.
- The MCO tax was updated to account for the halt in disenrollment during the PHE.
    - As noted above, significant deviations from projected enrollment were observed due to the continuation of the PHE past the assumed termination date.

<u>Updated Calendar Year (CY) 2022 Coordinated Care Initiative (CCI) Rates</u>

On May 12, 2023, DHCS provided CalOptima Health with updated CY 2022 CCI capitation rates. Staff received authority during the March 2022 meeting of the CalOptima Health Board of Directors to incorporate the previous final version of the CY 2022 CCI rates into CalOptima Health's Primary Agreement with the DHCS. *See,* Attachment 3_CY 2022 Full Dual CCI Rates.

DHCS noted that these rates will be further updated in the third quarter of 2023 to include the budget neutral split in rates for the UIS and SIS populations. The details of CalOptima Health's updated CY 2022 rates are outlined below.

Programmatic Changes

- Implementation of an additional 10% unit cost increase in accordance with the COVID-19 PHE fee schedule increase for LTC facilities (including hospice room and board).
    - The prior CY 2022 rates assumed that the PHE would end prior to the rating period; therefore, the additional fee schedule increase was not reflected in the prior version of the rates.

Add-Ons

- The MOT add-on was updated to reflect finalized UC case rates.

The anticipated impact of these proposed rate changes is identified in the Fiscal Impact section below.

Fiscal Impact
DHCS's updated changes included in the amendment result in a 0.5% increase in Medi-Cal base revenue from what was incorporated in CalOptima Health's financials for CY 2022. This increase was primarily driven by the LTC unit cost increase. Staff will refresh the financials before the end of the current fiscal year to account for the rate changes.

Rationale for Recommendation
DHCS develops capitation rates according to base data reported by CalOptima Health through the rate development template process and adjusted for trends and program changes. Execution of the contract amendment will ensure revenues, expenses, and cash payment are consistent with the approved budget to support CalOptima Health operations.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
1. Appendix summary of amendments to Primary Agreements with DHCS
2. CY 2022 Rates March 2022
3. CY 2022 Full Dual CCI Rates

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 5

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

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

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

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A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A–45 incorporates the new requirements of the 2018 Final Rule Amendment, Behavioral Health Treatment (BHT) and State Fiscal Year (SFY) 2018 – 19 capitation rates	June 7, 2018 August 1, 2019 August 6, 2020
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-47 incorporates full dual rates for Calendar Year (CY) 2019.	October 1, 2020

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A-48 incorporates new Bridge Period, Health Homes Program (HHP) and Whole Child Model (WCM) language and adds 2019 – 2020 capitation rates	June 7, 2018 October 1, 2020 February 4, 2021
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020
A-50 incorporates full dual rates for Calendar Year (CY) 2020.	February 4, 2021
A-51 incorporates full dual rates for Calendar Year (CY) 2021.	February 4, 2021
A-52 incorporates Calendar Year (CY) 2021 base amendment contract language.	October 7, 2021
A-53 incorporates Calendar Year (CY) 2021 fall amendment contract language.	October 7, 2021
A-54 extends the Primary Agreement with DHCS to December 31, 2022.	October 7, 2021
A-55 incorporates full dual rates for Calendar Year (CY) 2022.	March 3, 2022
A-56 incorporates updated Bridge Period (July 1, 2019 – December 31, 2020) capitation payment rates that are now split into rates for Satisfactory Immigration Status (SIS) and Unsatisfactory Immigration Status (UIS) members, and includes new corresponding rate tables that split each existing category into a SIS and UIS version.	October 1, 2020
A-57 incorporates Calendar Year (CY) 2022 risk mitigation language.	March 3, 2022
A-58 incorporates the COVID Vaccination Incentive Program.	March 3, 2022
A-59 incorporates new Calendar Year (CY) 2022 capitation rates and benefit changes implemented in CY 2022	August 5, 2021 March 3, 2022 August 4, 2022
A-60 incorporates new benefits changes for Calendar Year (CY) 2022.	August 4, 2022
A-62 extends the Primary Agreement with DHCS to December 31, 2023.	May 5, 2022
A-63 incorporates new benefits changes for Calendar Year (CY) 2023.	February 2, 2023

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)

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A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020
A-12 extends the Secondary Agreement with DHCS to December 31, 2022.	October 7, 2021
Agreement 22-20494 incorporates both Hyde services ("Private Services") and the new Unsatisfactory Immigration Status members from January 1, 2023 to December 31, 2023.	December 1, 2022
A-01 incorporates rates for CY 2023 for Hyde services (now referred to as "Private Services") and the new Unsatisfactory Immigration Status (UIS) members.	December 1, 2022

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2022.	June 3, 2021
A-06 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	May 5, 2022
A-07 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	October 6, 2022
A-08 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	Not applicable due to non – substantive changes.

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

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

11. Authorize and Direct Execution of Amendment(s) to CalOptima's Primary Medi-Cal Agreement with the California Department of Health Care Services Related to Rate Changes

Contacts

Carmen Dobry, Executive Director, Compliance, (657) 235-6997
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Medi-Cal Agreement between the California Department of Health Care Services and CalOptima related to rate changes.

Background

As a County Organized Health System (COHS), CalOptima contracts with the California Department of Health Care Services (DHCS) to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with the DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 54, which extends the agreement through December 31, 2022. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to ensure that the Medi-Cal members DHCS assigns to CalOptima have access to covered health care services.

Discussion

DHCS has informed Managed Care Plans (MCPs), including CalOptima, that it will submit an agreement amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate rate changes related to Base Medi-Cal Classic rates, ACA Optional Expansion (OE) rates, Coordinated Care Initiative (CCI) Non-Full Dual rates, Hyde (Abortion) rates, Behavioral Health Treatment (BHT) supplemental payments, Managed Long–Term Services and Supports (MLTSS) add–on rates, and Proposition 56 directed payments.

Rate Changes

DHCS's proposed agreement amendment seeks to incorporate rates related to Base Medi-Cal Classic rates, ACA Optional Expansion (OE) rates, CCI Non-Full Dual rates, Hyde (Abortion) rates, BHT supplemental payments, MLTSS add–on rates, and Proposition 56 directed payments.

CY 2022 Rates

Base Classic Medi–Cal and ACA Optional Expansion Rates

Noteworthy items for the updated rates for January 2022 to December 2022 include, but are not limited to:

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- MCO tax add-on
- Program changes (as specified below)
- Risk adjustment updates
- Major Organ Transplant rate add-on
- Final Directed Payments/Pass-through payments
- Final projected enrollment

The base Medi–Cal Classic and ACA OE capitation rates for January 1, 2022 through December 31, 2022 were first sent to CalOptima as draft rates in July 2021, as updated draft rates in October 2021, and as final rates in January 2022. The rates reflect a rate rebase that now utilizes CY 2019 experience, including health plan submitted Rate Development Templates (RDTs) and encounter data. The rebase also includes the following:

- Base data adjustments for program changes such as:
  - Psychiatric Collaborative Care (PCC)
  - COVID-19 adjustments for mental health, testing, and treatment
  - Community Supports
  - Whole Person Care (WPC) related to Community Supports
  - Doula Benefit
  - Remote Patient Monitoring
  - Rapid Whole Genome Sequencing
  - Community Health Worker
  - Transitioning populations under CalAIM and for undocumented members aged 50 and over.

- Rate add -ons for the following:
  - MCO Tax
  - Proposition 56 Directed Payments
  - Hospital Quality Assurance Fee (HQAF) Payments
  - Major Organ Transplant (MOT)
  - Seniors and Persons with Disabilities (SPD) Community – Based Adult Services (CBAS)
  - Enhanced Care Management (ECM)

- Projected non-benefit costs for administrative and underwriting gain loads.
- Projected enrollment reflecting DHCS's current best estimate of enrollment for the CY 2022 rating period.
- Whole Child Model (WCM) rates utilizing a one-year base period, consistent with broader mainstream rates.
- CCI non – dual MLTSS capitation rates.
- Updated BHT supplemental payment rates using a CY 2018 and CY 2019 base data time period.

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CY 2022 ECM Add-on Per member per month (PMPM)

CalOptima received draft Enhanced Care Management (ECM) rates for January 2022 through December 2022 in May 2021 and final ECM rates in September 2021. Highlights regarding the ECM rate amounts include the following:

- Assumption changes impacting per enrollee per month (PEPM) costs
  - Service hours/caseloads: service hours and corresponding caseloads used in ECM base costs remain consistent.
  - Provider type salaries, trend and provider overhead: increase to base salaries and benefits for full time employees (FTE) providing ECM services.
  - Administrative load: full administrative load built into final ECM PMPM add-on rates.
- Assumption changes impacting ECM enrolled member counts
  - Whole Person Care (WPC) transitioning ECM members: assumed projected increase for transitioning WPC members remaining in ECM after six months.
  - Health Homes Program (HHP) transitioning ECM members: assumed projected increase for transitioning HHP members to remain in ECM after six months.
  - Identifying ECM eligible members for outreach and enrollment: number of members who would be ECM-eligible has increased based on updated analysis.
  - Modification of logic for health plans/counties with high WPC/HHP counts: updated rate methodology to acknowledge the resources required for transitioning WPC/HHP members into ECM.
- Other assumption changes
  - Outreach costs: outreach assumptions were revised to reflect the amount of hours spent on each outreach target.
  - Projected managed care enrollment update: the final ECM rates utilize updated 12-month projected enrollment counts that are based on actual enrollment observed through April 2021 with supplemental information through May 2021.

CY 2022 Community Supports Rates

CalOptima received draft Community Supports (ILOS) rates for January 2022 through December 2022 in August 2021 and final rates in January 2022.

Highlights regarding the Community Supports rate amounts include fully loaded PMPMs based on the following:

- Community Supports expense data provided in CalOptima's RDT submission.
- Whole Person Care (WPC) data.
- Community Supports within the CY 2022 capitation rates.

For further details regarding CalOptima's CY 2022 rates, please see "Attachment 2_Detailed Description of CY 2022 Rates."

The anticipated impact of these proposed rate changes is identified in the Fiscal Impact section.

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Fiscal Impact

Base Classic Medi-Cal and ACA Optional Expansion Rates:
Compared to CY 2021 rates, the final CY 2022 final rates are 11.6% or $22.48 PMPM higher for Medi-Cal Classic, 6.7% or $21.02 PMPM higher for Medi-Cal Expansion, and 18.6% or $269.41 PMPM higher for Medi-Cal WCM members. In aggregate, Staff projects the net fiscal impact for the period January 1, 2022, through June 30, 2022, will be more favorable than the assumptions included in the CalOptima Fiscal Year (FY) 2021-22 Operating Budget. Staff will include updated rates for the period of July 1, 2022, through December 31, 2022, in the CalOptima FY 2022-23 Operating Budget.

ECM and Community Support Services Rates:
The FY 2021-22 Operating Budget assumes that CalOptima will take financial risk for the mandatory ECM benefit and optional Community Support services effective January 1, 2022. Payments related to these new benefits and services were treated as budget neutral.

Rationale for Recommendation

DHCS develops capitation rates according to base data reported by CalOptima through the RDT process and adjusted for trends and program changes. Execution of the contract amendment will ensure revenues, expenses and cash payment are consistent with the approved budget to support CalOptima operations.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Appendix summary of amendments to Primary Agreements with DHCS
2. Detailed Description of CY 2022 Rates

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 11

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

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

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

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A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A–45 incorporates the new requirements of the 2018 Final Rule Amendment, Behavioral Health Treatment (BHT) and State Fiscal Year (SFY) 2018 – 19 capitation rates	June 7, 2018 August 1, 2019 August 6, 2020
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-47 incorporates full dual rates for Calendar Year (CY) 2019.	October 1, 2020

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A-48 incorporates new Bridge Period, Health Homes Program (HHP) and Whole Child Model (WCM) language and adds 2019 – 2020 capitation rates	June 7, 2018 October 1, 2020 February 4, 2021
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020
A-50 incorporates full dual rates for Calendar Year (CY) 2020.	February 4, 2021
A-51 incorporates full dual rates for Calendar Year (CY) 2021.	February 4, 2021
A-52 incorporates Calendar Year (CY) 2021 base amendment contract language.	October 7, 2021
A-53 incorporates Calendar Year (CY) 2021 fall amendment contract language.	October 7, 2021
A-54 extends the Primary Agreement with DHCS to December 31, 2022.	October 7, 2021
A-55 incorporates full dual rates for Calendar Year (CY) 2022.	March 3, 2022
A-57 incorporates Calendar Year (CY) 2022 risk mitigation language.	March 3, 2022
A-58 incorporates the COVID Vaccination Incentive Program.	March 3, 2022

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

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

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A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020
A-12 extends the Secondary Agreement with DHCS to December 31, 2022.	October 7, 2021

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2023.	June 3, 2021

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

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

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Detailed Description of CY 2022 Rates

The CY 2022 capitation rates may be amended later in year for the following reasons:

- Updates to capitation rates may occur when more information on the Public Health Emergency (PHE) end date is known.
- Capitation rates will be updated to separate the rates for beneficiaries with satisfactory immigration status versus unsatisfactory immigration status.

Program Changes, Efficiencies, and Other Adjustments:

a) All adjustments to the base data are listed below:

i. Psychiatric Collaborative Care (PCC)
ii. Prop 56 Community Based Adult Services (CBAS)
iii. Non-Medical Transportation (NMT)
iv. SB 523 Ambulance increases (GEMT)
v. Optional Benefits (Vision, Audiology, Podiatry, Incontinence creams and washes, and Speech Therapy)
vi. Long-Term Care (LTC)
vii. Hospice
viii. COVID Adjustments for Mental Health and Testing and Treatment
ix. Doula Benefit
x. Community Supports (ILOS) – approved ILOS reported in the CY 2019 RDT
xi. Whole Person Care (related to CalAIM ILOS)
xii. Remote Patient Monitoring
xiii. Continuous Glucose Monitoring DME Carve-out
xiv. Community Health Worker
xv. Populations transitioning from FFS to Managed Care (including those under CalAIM)
xvi. Population transition for members aged 50 and over to Full Scope Benefits regardless of immigration status (Undocumented 50+)
xvii. Rapid Whole Genome Sequencing
xviii. Dyadic Behavioral Health
xix. Population Acuity Adjustment
xx. Potentially Preventable Admissions efficiency adjustment (PPA)
xxi. Healthcare Common Procedure Coding System efficiency adjustment (HCPCS)
xxii. Emergency Department (ED) Adjustment for Low Acuity Non-Emergency (LANE) visit

Enrollment

This membership projection assumes the PHE will end in December 2021 and that DHCS will work through the backlog of eligibility redetermination within 12 months. These projections are based on actual enrollment with runout through July 2021 with supplemental information with runout through August 2021. This projected enrollment has been updated with best estimates for the CalAIM transitioning populations and undocumented 50+ groups.

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Rate Add-Ons

Proposition 56
For the Physician, Developmental Screening, Trauma Screening, Family Planning, and Value-Based Purchasing (VBP) Prop 56 directed payments, the PMPM add-ons were adjusted for population acuity (consistent with the adjustment made for the broader rates) and populations transitioning from FFS to Managed Care.

The VBP Prop 56 directed payments were further adjusted for the transitioning population aged 50 and older with unsatisfactory immigration status that will transition to full-scope benefits during the CY 2022 rating period. VBP Prop 56 is scheduled to sunset as of July 1, 2022.

Hospital Quality Assurance Fee (HQAF) – the HQAF pass-through payment PMPM add-ons have been revised for final rates, due to enrollment projection updates.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

10. Ratify an Amendment to CalOptima's Primary Medi-Cal Agreement with the California Department of Health Care Services (DHCS) Related to Rate Changes

Contacts

Carmen Dobry, Executive Director, Compliance, (657) 235-6997
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action

Ratify Amendment to CalOptima's Primary Agreement between CalOptima and the DHCS related to rate changes.

Background

As a County Organized Health System (COHS), CalOptima contracts with the DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with the DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 54, which extends the agreement through December 31, 2022. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to ensure that the Medi-Cal members DHCS assigns to CalOptima have access to covered health care services.

Discussion

On January 24, 2022, DHCS requested that CalOptima sign and return the CY 2022 CCI Full Dual Rates Agreement Amendment as soon as possible, but no later than Friday, February 18, 2022. In order to meet DHCS's deadline, CalOptima staff procured the Chair's signature on Thursday, February 3, 2022, and returned the signed agreement amendment to DHCS. As such, staff requests the CalOptima Board of Directors' ratification of the Board Chair's execution of the CY 2022 CCI Full Dual rates agreement amendment with the DHCS.

Rate Changes

DHCS's agreement amendment incorporates rates related to CCI Full Dual rates for the period of January 1, 2022, through December 31, 2022.

CY 2022 CCI Full Dual Rates

CY 2022 CCI Full Dual Rates

CalOptima received CY 2022 CCI full dual draft rates in September 2021 and final CY 2022 CCI full dual rates in January 2022. Highlights regarding these rates are as follows:

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- Final CY 2022 projected enrollment assumes the Public Health Emergency (PHE) will end in December 2021.
- Updated trend levels to reflect expected Mental Health Outpatient (MHOP) utilization and unit cost increases from CY 2019 base period to the CY 2022 contract period.
- The rates reflect a rebase that utilizes CY 2019 experience including health plan submitted RDTs and encounter data.
- The rebase also includes the following base-data adjustments:
    - Community Supports (formerly In Lieu of Services) – appropriately reported ILOS costs were removed from base data experience.
    - Global administrative adjustment for health plans who globally subcontract to another health plan.
    - Multipurpose Senior Services Program (MSSP) – data and cost for the MSSP Category of Service (COS) was removed from the base data due to MSSP services being carved out of managed care in CY 2022.
    - Category of aid (COA) adjustment – MSSP – only data reported in CY 2019 CCI RDTs was utilized to adjust the COA structure of the base data to match the COA structure of the CY 2022 rate period.
- Ground Emergency Medical Transportation (GEMT) adjustments
- Long – term care (LTC) program change, accounting for facility fee changes, was updated based on more recently published facility rate information.
- Program change adjustment quantifying the impact of adding skilled and trained Community Health Workers (CHWs) effective July 1, 2022.
- Non – medical transportation (NMT) amounts.
- Optional benefits restoration effective January 1, 2020.
- COVID-19 adjustment for mental health.
- Adjustments to the Whole Person Care (WPC) portion of Community Supports (ILOS) to utilize Eligible But Not Enrolled (EBNE) data rather than Cal MediConnect (CMC) data.
- These rates do not reflect any costs associated with pharmacy services for non – Cal MediConnect (CMC) COAs due to the pharmacy carve – out as of January 1, 2022.
- Rate add – ons for Enhanced Care Management (ECM) and Major Organ Transplant (MOT).
- MCO tax adjustments

The anticipated impact of these proposed rate changes is identified in the Fiscal Impact section.

Fiscal Impact

Compared to CY 2021 rates, the final CY 2022rates are 0.3% or $1.31 PMPM higher for CCI Full Dual members. In aggregate, Staff projects the net fiscal impact for the period January 1, 2022, through June 30, 2022, will be slightly more favorable than the assumptions included in the CalOptima Fiscal Year (FY) 2021-22 Operating Budget. Staff will include updated rates for the period of July 1, 2022, through December 31, 2022, in the CalOptima FY 2022-23 Operating Budget.

Rationale for Recommendation

DHCS develops capitation rates according to base data reported by CalOptima through the Rate Development Template (RDT) process and adjusted for trends and program changes. Execution of the

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contract amendment will ensure revenues, expenses and cash payment are consistent with the approved budget to support CalOptima operations.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Hunn *02/24/2022*

Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 10

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

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

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

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A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A–45 incorporates the new requirements of the 2018 Final Rule Amendment, Behavioral Health Treatment (BHT) and State Fiscal Year (SFY) 2018 – 19 capitation rates	June 7, 2018 August 1, 2019 August 6, 2020
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-47 incorporates full dual rates for Calendar Year (CY) 2019.	October 1, 2020

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A-48 incorporates new Bridge Period, Health Homes Program (HHP) and Whole Child Model (WCM) language and adds 2019 – 2020 capitation rates	June 7, 2018 October 1, 2020 February 4, 2021
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020
A-50 incorporates full dual rates for Calendar Year (CY) 2020.	February 4, 2021
A-51 incorporates full dual rates for Calendar Year (CY) 2021.	February 4, 2021
A-52 incorporates Calendar Year (CY) 2021 base amendment contract language.	October 7, 2021
A-53 incorporates Calendar Year (CY) 2021 fall amendment contract language.	October 7, 2021
A-54 extends the Primary Agreement with DHCS to December 31, 2022.	October 7, 2021
A-55 incorporates full dual rates for Calendar Year (CY) 2022.	March 3, 2022
A-57 incorporates Calendar Year (CY) 2022 risk mitigation language.	March 3, 2022
A-58 incorporates the COVID Vaccination Incentive Program.	March 3, 2022

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

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

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A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020
A-12 extends the Secondary Agreement with DHCS to December 31, 2022.	October 7, 2021

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2023.	June 3, 2021

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

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

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

6. Adopt Resolution No. 23-0601-01, Authorizing and Directing Execution of Contract MS-2324-41 with the California Department of Aging for the Multipurpose Senior Services Program for Fiscal Year 2023-24

Contacts

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

Recommended Actions

Adopt Board Resolution No. 23-0601-01, authorizing and directing the Chairman of the Board of Directors (Board) to execute Contract MS-2324-41 with the California Department of Aging for the Multipurpose Senior Services Program for Fiscal Year 2023-24.

Background

The Multipurpose Senior Services Program (MSSP) is a home and community-based services program, operated pursuant to a waiver in the State of California's Medi-Cal program. MSSP provides case management of social and health care as a cost-effective alternative to institutionalization of frail, older persons.

The California Department of Health Care Services (DHCS), through an Interagency Agreement, delegates the administration of the MSSP to the California Department of Aging (CDA). The CDA contracts with local government entities and private non-profit organizations for local administration of the MSSP in various areas of the State.

As the operator of the MSSP site for Orange County, CalOptima Health improves the quality of care for its aging population by linking frail, older members to home and community-based services as an alternative to institutionalization and helps to contain long-term care costs by reducing unnecessary or inappropriate nursing facility placements. CalOptima Health has successfully implemented the MSSP program over the past 22 years for up to 568 members at any given point in time.

Discussion

CalOptima Health received CDA contract MS-2324-41 for execution by the Chairman of the CalOptima Health Board, which, upon the adoption of a BOARD resolution and execution of the contract, will extend the MSSP through June 30, 2024, with the maximum of the contract spend set at $3,042,208.

The scope of work and other obligations are consistent with existing CDA contract obligations. The MSSP administration does not anticipate that any changes defined within the attached Contract Summary of Changes will have a significant operational or financial impact as they are largely already in operation. *See,* Attachment 2, California Department of Aging (CDA) 9008: Contract Summary of Changes (SOC).

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The Summary of Changes outlined in the MSSP Fiscal Year 2023-24 Exhibits Reference Sheet will be implemented and adhered to.

Fiscal Impact

Staff has incorporated projected revenue and expense related to the MSSP program in the CalOptima Health Fiscal Year 2023-24 Operating Budget, pending Board approval.

Rationale for Recommendation

Adoption of Board Resolution No. 23-0601-01, authorizing and directing the Chairman of the Board to execute the Fiscal Year 2023-24 contract with the CDA for the MSSP will allow CalOptima Health to continue to address the long-term community care needs of some of the frailest older adult CalOptima Health members by helping them to remain in their homes.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Board Resolution No. 23-0601-01, Execute Contract No. MS-2324-41.
2. California Department of Aging (CDA) 9008: Contract Summary of Changes (SOC)

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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RESOLUTION NO. 23-0601-01

RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY
Orange Prevention and Treatment Integrated Medical Assistance
d.b.a. CalOptima Health

EXECUTE CONTRACT NO. MS-2324-41
WITH THE STATE OF CALIFORNIA
DEPARTMENT OF AGING FOR THE
MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

WHEREAS, the Orange County Health Authority, d.b.a. CalOptima Health ("CalOptima Health") continues to provide services as a Multipurpose Senior Service Program site under contract with the California Department of Aging; and,

WHEREAS, the California Department of Aging notified CalOptima Health of its intent to contract for the assignment of 568 MSSP participant slots to CalOptima Health; and,

WHEREAS, the California Department of Aging has requested the execution of Contract MS-2324-41 ("Contract"); and,

WHEREAS, the Board of Directors has determined that it is in the best interest of the ongoing development of CalOptima Health home and community-based services to the Medi-Cal beneficiaries residing in Orange County to approve CalOptima Health executing the Contract.

NOW, THEREFORE, BE IT RESOLVED:

I. That CalOptima Health is hereby authorized to enter into contract MS-2324-41 with the State of California Department of Aging on the terms and conditions set forth in the form provided to this Board of Directors; and,

II. That the Chair of this Board of Directors is hereby authorized and directed to execute and deliver the Contract by and on behalf of CalOptima Health on the terms and conditions set forth in the form provided to this Board of Directors.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima Health, this 1st day of June 2023.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Clayton Corwin, Chair, Board of Directors

Attest:
/s/_____
Sharon Dwiers, Clerk of the Board

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STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING

CONTRACT SUMMARY OF CHANGES

CDA 9008 (NEW 6/16)

Program: CDA-MSSP

Contract Number: MS2324

Contract Term: Fiscal Year July 2023- June 2024

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
EXAMPLE: Exhibit A, Article II.A.4.	**EXAMPLE:** n/a	**EXAMPLE:** c) Include staff timesheets that detail how much time is spent on each activity.	**EXAMPLE:** New regulatory language added by the CA Dept. of Oversight	**EXAMPLE:** Sam Smith
Exhibit B. Article III. D.	The Budget shall include following items: Equipment Supplies.	5. Equipment: Equipment Cost equal to or greater than $5,000 per Unit (Any Computing Equipment regardless of Cost) - detailed descriptions and unit costs needs to be identified on the Equipment tab in the Budget Template. 7. Equipment, Maintenance & Rental Costs; Supplies.	Matching descriptions with Budget template and providing further clarification for budget line items	MSSP Fiscal Team
Exhibit D Article VII. E.	CDA tag number or other tag identifying it as State of California property	CDA tag number	BMB requested updated language to verify only CDA tags are used	BMB/MSSP
Exhibit D Article I. A 18, 19, 21	2 CFR 200.4, 200.31, 200.84	2 CFR 200.1	Outdated references	Audits
Exhibit D Article I. A	"Recoverable cost" means the state and federal share of the questioned cost.	"Recoverable cost" means the questioned cost identified from an audit.	Audits does not differentiate between state and federal share when determining the recoverable amount.	Audits

STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
CONTRACT SUMMARY OF CHANGES
CDA 9008 (NEW 6/16)

Program: CDA-MSSP
Contract Number: MS2324
Contract Term: Fiscal Year July 2023- June 2024

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
Exhibit D Article I. B	B. Resolution of Language Conflicts	I'm wondering if we should cite the 2 CFR 200 in this list	It is used as criteria.	Audits
Exhibit D Article II. H.	This section applies only to Title III funds…	All language in this section regarding Title III funds should be removed.	MSSP doesn't have Title III funding.	Audits
Exhibit D Article II. M.	DUNS Number and Related Information	I believe DUNS changed to UEI, should this be changed? https://sam.gov/content/duns-uei		Audits
Exhibit D Article VI. A.	"…and a summary worksheet identifying the results of performing an audit resolution of its subcontractors in accordance with Article X of this Exhibit."	Remove this language	MSSP doesn't perform resolution of its subcontractors.	Audits
Exhibit D Article VI. B.	All such records, including confidential records, must be maintained and made available by the Contractor: (1) until an audit has occurred and an audit resolution has been issued or unless otherwise authorized in writing by CDA's or DHCS' Audit Branch…	All such records, including confidential records, must be maintained and made available by the Contractor: (1) until an audit of the July 1, 2023 through June 30, 2024 period of expenditures has occurred and an audit resolution has been issued or unless otherwise authorized in writing by CDA's Audit and Risk Management Branch, or DHCS' Audit Branch…	Make it more clear about when they can dispose of records. They are audited every other year, so we want to make sure these records are maintained until we have audited this specific time period.	Audits

STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING

CONTRACT SUMMARY OF CHANGES

CDA 9008 (NEW 6/16)

Program: CDA-MSSP

Contract Number: MS2324

Contract Term: Fiscal Year July 2023- June 2024

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
Exhibit D Article VI. E.	Adequate source documentation of each transaction shall be maintained relative to the allowability of expenditures reimbursed by the DHCS under this Agreement.	Adequate source documentation of each transaction shall be maintained relative to the allowability of expenditures reimbursed by the DHCS under this Agreement. Source documentation includes, but is not limited to: vendor invoices, bank statements, cancelled checks, bank/credit card statements, contracts and agreements, employee time sheets, purchase orders, indirect cost allocation plans.	Better language for criteria. Some AAAs have given push back when we ask for the copies of cancelled checks or other proof of payment.	Audits
Exhibit D Article X. A2.	Contractor shall make available all reasonable information necessary to substantiate that expenditures under this agreement are allowable and allocable, including, but not limited to books, documents, papers, and records.	Contractor shall make available all reasonable information necessary to substantiate that expenditures under this agreement are allowable and allocable, including, but not limited to accounting records, vendor invoices, bank statements, cancelled checks, bank/credit card statements, contracts and agreements, employee time sheets, purchase orders, indirect cost allocation plans.	To be more specific so that the contractor is aware of the documents we will look at during an audit.	Audits
Exhibit D Article X. B2.a and c	2 CFR 200.16 and 200.4	These both should be 200.1	Outdated references.	Audits

STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
CONTRACT SUMMARY OF CHANGES
CDA 9008 (NEW 6/16)

Program: CDA-MSSP
Contract Number: MS2324
Contract Term: Fiscal Year July 2023- June 2024

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
Exhibit D Article 1 B.	Resolution of Language Conflicts The terms and conditions of this Agreement have the following order of precedence, if there is any conflict in what they require: 1. Section 1915(c) of Title XIX of the Social Security Act, 42 USC 1396n, 2 CFR 200, et. seq., and other applicable federal statutes and their implementing regulations. 2. The Interagency Agreement Terms and Conditions. 3. As applicable, Welfare and Institutions Code Sections 9560 to 9568 and other California State codes and regulations governing the MSSP.	Resolution of Language Conflicts Should the terms and conditions of this Agreement be found to conflict with one another the following order of authority shall control: 1. Statutory Law, subject to the doctrine of preemption, including, but not limited to: Section 1915(c) of Title XIX of the Social Security Act, 42 USC 1396n, Welfare and Institutions Code Sections 9560 to 9568, other Federal and California state codes and regulations governing the MSSP and/or other applicable Federal and California state	Corrected CFR language and updated precedence.	Legal

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
	4. Standard Agreement (Std. 213), all Exhibits and any amendments thereto. 5. Any other documents incorporated herein by reference including, but not limited to, the MSSP Site Manual. 6. Program memos and other guidance issued by CDA.	statutes and their implementing regulations. 2. Standard Agreement (Std. 213), all Exhibits and any amendments thereto. 3. Any other documents incorporated herein by reference including, as applicable, the MSSP Site Manual found at https://www.aging.ca.gov/ProgramsProviders/MSSP/. 4. Program memos and other guidance issued by CDA.		
			.	

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Approve New CalOptima Health Policy GG.1667: CalAIM Population Health Management Program

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Marie Jeannis, RN, MSN, CCM, Executive Director, Population Health Management, (714) 246-8591

Recommended Actions

Approve new CalOptima Health Policy GG.1667: CalAIM Population Health Management Program, in accordance with regulatory requirements.

Background

As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative and pursuant to state law, the Department of Health Care Services (DHCS) is implementing a Population Health Management (PHM) Program. The PHM Program requires managed care health plans to implement a program, under a common framework, which is responsive to individual member needs within the communities they serve. The PHM Program is a cohesive statewide approach that consolidates and expands existing population health strategies to ensure member access to services and programs, along the continuum of care, according to member risk, needs and preferences.

Discussion

CalOptima Health establishes new policies and procedures to implement federal and state laws, programs regulations, contracts, and business practices. Additionally, CalOptima Health staff performs annual policy reviews to add or update internal policies and procedures to ensure compliance with applicable requirements. In November 2022, DHCS released All-Plan Letter (APL) 22-024: *Population Health Management Policy Guide* with guidance for the delivery of the PHM Program.

The purpose of the new GG.1667: CalAIM Population Health Management Program policy is to describe the process and services by which CalOptima Health, delegated Health Networks, and providers engage members across delivery systems in accordance with DHCS APL 22-024. This policy describes the comprehensive set of services for members across the continuum of care to promote improved outcomes.

Fiscal Impact

The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the Fiscal Year 2022-23 Operating Budget.

Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations, staff recommends that the CalOptima Health Board

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of Directors approve and adopt CalOptima Health Policy GG.1667: CalAIM Population Health Management Program for Medi-Cal members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Policy GG.1667: CalAIM Population Health Management Program

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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Policy:	GG.1667p
Title:	**CalAIM Population Health Management Program**
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	*/s/*
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines CalOptima Health's Population Health Management (PHM) program and describes the process by which CalOptima Health, Delegated Health Networks, and Providers engage Members across delivery systems and carved-out services.

II. POLICY

A. CalOptima Health shall establish and maintain a PHM Program in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Program.

B. The PHM Program ensures that all Members have access to a comprehensive set of services based on their individual needs and preferences across the continuum of care, which promotes improved outcomes, and Health Equity.

C. The PHM Program shall align with the National Committee for Quality Assurance (NCQA) Health Plan Accreditation PHM standards.

D. The PHM Program includes basic population health management, care management, complex care management, enhanced care management, and transitional care services.

E. The PHM Program will include four domains that define the PHM Framework:

1. PHM Strategy and Population Needs Assessment;

2. Gathering Member Information;

3. Understanding Risk; and

4. Providing Services and Supports.

F. CalOptima Health will meet the requirements of the PHM Framework domains in accordance with Section III of this policy.

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G. The goal of the PHM program is to:

1. Build trust and meaningfully engagement with Members;

2. Provide interventions to support health and wellness for all Members;

3. Utilize data-driven Risk Stratification, standardize assessment processes and predictive analytics to address gaps in care;

4. Provide care management services for Members with increased risk of poor outcomes;

5. Robust transitional care services (TCS);

6. Identify and mitigate social drivers of health to reduce disparities; and

7. Address upstream factors by linking Members to public health and social services.

H. DHCS will provide a PHM Service, a single, statewide, open-source RSS methodology, to support key PHM Program functions which include but not limited to:

1. Data integration;

2. Risk Stratification, segmentation, tiering;

3. Screening and Assessment;

4. Analytics and Reporting; and

5. User access to data.

I. CalOptima Health will integrate and use the PHM Service for Risk Stratification, screening, and assessment once launched and made widely available by DHCS.

III. PROCEDURE

A. PHM Strategy

1. The PHM strategy is a comprehensive, accountable plan of action for addressing Member needs and preferences.

2. CalOptima Health shall develop an annual PHM Strategy that:

a. Outlines the PHM program;

b. Prioritizes strong ties to the community;

c. Incorporates cross-sector strategies to improve health in all neighborhoods and communities where Members reside, especially those with poor health outcomes; and

d. Include strategies for improving access to children's preventive health visits and developmental screenings, ensuring follow up and Care Coordination needs identified from screenings delivered.

3. PHM Strategy shall align with the DHCS Comprehensive Quality Strategy (CQS) Clinical Focus Areas and Bold Goals.

    a. Clinical Focus Areas – DHCS defines three focus areas:

        i. Children's preventive care;

        ii. Maternity care and birth equity; and

        iii. Behavioral health integration.

    b. Bold Goals – DHCS has defined and identified the following Bold Goals for year 2025:

        i. Close racial/ethnic disparities in well-child visits and immunizations;

        ii. Close maternity care disparity for Black and Native American persons by 50%;

        iii. Improve maternal and adolescent depression screening by 50%;

        iv. Improve follow up for mental health and substance use disorder by 50%; and

        v. Ensure all health plans exceed the 50th percentile for all children's preventive care measures.

4. Annually CalOptima Heath shall review, update and submit the PHM strategy to DHCS.

B. Population Needs Assessment

1. CalOptima Health shall conduct a Population Needs Assessment in accordance with CalOptima Health Policy GG.1201: Health Education Programs, to gather and evaluate population-level data related to the health and Social Needs of Members, including:

    a. Cultural, linguistic, and health education needs;

    b. Health disparities and inequities; and

    c. Root causes of barriers related to coverage, access, quality, health outcomes, and social drivers of health (SDOH).

2. CalOptima Health will evaluate, update and submit the PNA to DHCS every three (3) years.

C. Gathering Member Information

1. CalOptima Health will use a Risk Stratification and Segmentation (RSS) methodology to identify each Member's health and Social Needs, as well as their health goals and preferences.

2. CalOptima Health will leverage a broad set of data sources in the RSS methodology which includes , but is not limited to:

    a. Managed care and fee for service medical and dental claims and encounters;

    b. Screenings and assessments;

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c. Race, ethnic, and language information;

d. Disability status;

e. Admissions, discharge and transfer (ADT) data;

f. Referrals and authorizations;

g. MCP behavioral health Screenings, Brief Interventions, and Referral to Treatment (SBIRT), medications for addiction treatment, and other substance use disorders (SUD) and other non-specialty mental health services information;

h. County behavioral health Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), and Specialty Mental Health System (SMHS) information;

i. Pharmacy claims, encounters;

j. Laboratory results;

k. Housing status utilizing ICD 10 Z-code;

l. For Members under twenty-one (21), developmental and adverse childhood experiences (ACEs) screenings; and

m. Additional data from the DHCS PHM Service which includes but not limited to:

i. Social services reports;

ii. Electronic Health Records;

iii. Disengaged Member reports;

iv. Justice Involved Data; and

v. Homelessness Management Information System (HMIS).

3. Initial Screening Process

a. CalOptima Health will screen newly enrolled Members by providing Health Information Form Member Evaluation Tool (HIF/MET) in accordance with CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services.

b. CalOptima Health shall review HIF/MET responses and provide additional outreach, Case Management, and Care Coordination activities in accordance with CalOptima Health Policies GG.1301: Comprehensive Case Management Process and GG.1201: Health Education Programs.

c. Member shall receive an Initial Health Appointment (IHA) in accordance with CalOptima Health Policy GG.1613 Initial Health Appointment.

d. Children and youth will be provided initial screenings in accordance with CalOptima Health Policy GG.1116: Pediatric Prevention Services.

D. Understanding Risk

1. CalOptima Health will utilize the following to understand a Member's risk:

   a. Risk segmentation and stratification (RSS); and

   b. Assessments and Reassessments.

2. Risk segmentation and stratification

   a. CalOptima Health will use a RSS approach that aligns with NCQA PHM standards as follows:

      i. Includes integration of data sources, findings from the PNA, clinical, behavioral, population, and Social Needs data, and a broad range of internal and external data;

      ii. Avoids and reduces biases to prevent exacerbation of health disparities by continuously evaluating key performance indicators and RSS outputs and monitoring health disparities over time;

      iii. Stratifies Members during each of the following time frames:

         a) Upon each Member's enrollment;

         b) At least annually after each Member's enrollment;

         c) Upon a significant change in health status or level of care of the Member; and

         d) Upon receipt of new information, CalOptima Health determines as potentially changing a Member's level of risk and need.

      iv. Places Members into risk tiers to identify those that should be connected to available interventions and services; and

      v. CalOptima Health's RSS methodology will be continuously evaluated for effectiveness.

3. Assessment and Reassessment

   a. CalOptima Health, its Health Networks, and Providers will ensure assessment and reassessment of the following Members:

      i. Those with long-term services and supports (LTSS) needs (as required by federal and state law and waiver)

      ii. Members entering Complex Case Management in accordance with CalOptima Health Policy GG.1301: Comprehensive Case Management Process.

      iii. Members entering Enhanced Care Management in accordance with CalOptima Health Policies GG.1353: CalAIM Enhanced Care Management Services Delivery, GG.1354: CalAIM Enhanced Care Management – Eligibility and Outreach, and GG.1356: CalAIM Enhanced Care Management Administration.

      iv. Children with Special Health Care Needs (CSHCN).

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v. Pregnant individuals in accordance with CalOptima Health Policy GG.1701: CalOptima Health Perinatal Support Services Program.

vi. Seniors and persons with disabilities who meet the definition of "high risk" as described in CalOptima Health Policies GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment, and GG.1324: Seniors and Persons with Disabilities (SPD) Comprehensive Case Management.

E. Providing Services and Supports

1. CalOptima Health's PHM program ensures Member support and services according to Member's risk, assessment and reassessment needs through the following:

a. Basic Population Health Management (BPHM);

b. Care Management Programs;

c. Enhanced Care Management (ECM); and

d. Transitional Care Services (TCS).

2. Basic Population Health Management (BPHM)

a. BPHM is a collaborative process that ensures all Members have access to:

i. Primary Care services in accordance with CalOptima Health Policy GG.1110: Primary Care Practitioner Definition Role, and Responsibilities:

a) BPHM will identify Members who are not using Primary Care through utilization and enrollment data stratified by race, ethnicity, and language for outreach to ensure member engagement with Members 'assigned PCPs.

ii. Coordination of care and Referrals for medical, carved out, linked, and Community Supports.

iii. Community Health Workers, in accordance with CalOptima Health PHM Strategy and CalOptima Health Policy GG.1213: Community Health Workers.

iv. Wellness and prevention programs in accordance with CalOptima Health Policy GG.1201: Health Education Programs.

v. Self-management tools in accordance with CalOptima Health Policy GG.1211: Health Appraisals and Self-Management Tools, and provide at a minimum information on the following areas:

a) Healthy weight (BMI) maintenance;

b) Smoking and tobacco use cessation;

c) Encouraging physical activity;

d) Healthy eating;

e) Managing stress;

f) Avoiding at-risk drinking; and

g) Identifying depressive symptoms.

vi. Disease Management programs in alignment with NCQA requirements at a minimum.

a) These programs will incorporate health education interventions, identify Members for engagement and seek to close care gaps with a focus on improving equity and reducing health disparities.

b) The Disease Management programs will address at a minimum the following conditions:

i) Diabetes;

ii) Cardiovascular disease;

iii) Asthma; and

iv) Depression.

vii. Programs to address maternal health outcomes including access to prenatal and postpartum care, in accordance with CalOptima Health Policy GG.1701: CalOptima Health Perinatal Support Services Program.

viii. CalOptima Health will develop strategies to address different utilization patterns in accordance with CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring.

ix. PHM for children that ensure all children under twenty-one (21) years of age with full scope Medi-Cal status will receive appropriate preventive, mental health, developmental and specialty EPSDT in accordance with CalOptima Health Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.

b. CalOptima Health's BPHM services will promote Health Equity and align with National Standards for Culturally and Linguistically Appropriate Services (CLAS).

c. BPHM will be provided to Members enrolled in ECM by the ECM Provider.

3. Care Management Programs

a. Complex Care Management (CCM)

i. CalOptima Health CCM services are provided to Members as mandated by federal and state regulations, and in accordance with CalOptima Health Policy GG.1301: Comprehensive Case Management Process.

ii. Member eligibility is determined by CalOptima Health's Risk Stratification process and in accordance with CalOptima Health Policy GG.1301: Comprehensive Case Management Process.

iii. CCM is provided to Members under the age of 21 in accordance with CalOptima Health Policies GG.1330: Case Management - California Children's Services Program/Whole-Child Model, and GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.

b. Enhanced Care Management (ECM)

i. CalOptima Health ECM services address the clinical and nonclinical needs of the highest-need Members through intensive coordination of health and health-related services, in accordance with CalOptima Health Policies GG.1353: CalAIM Enhanced Care Management Services Delivery, GG.1354: CalAIM Enhanced Care Management – Eligibility and Outreach, and GG.1356: CalAIM Enhanced Care Management Administration.

ii. Members cannot be enrolled in ECM and CCM at the same time.

c. Transitional Care Services (TCS)

i. CalOptima Health and Health Networks will provide transitional care services for Members transferring from one setting or level of care to another, including but not limited to: discharges from hospitals, institutions, other acute facilities, and skilled nursing facilities (SNFs) to home or community-based settings, community supports, post-acute care facilities, or long-term care (LTC) settings.

ii. CalOptima Health and Health Networks will develop and implement a plan to expand and ensure provision of TCS to the following populations:

a) Members identified as high-risk through RSS, in ECM, CCM or receiving LTSS, by January 2023.

b) All Members by January 2024.

iii. CalOptima Health will identify a care manager as a single point of contact for ensuring completion of all transitional care management services in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up after discharge.

iv. CalOptima Health will communicate with the responsible care manager and facility where patient is admitted in a timely manner so care manager can participate in discharge planning and support access to available services.

v. CalOptima will offer Members direct assistance of the care manager, however Members may choose to have limited to no contact with the care manager.

vi. CalOptima Health will ensure TCS care managers are notified within a timely manner of an admission, transfer, or discharge when an ADT feed is available OR a planned admission, transfer, or discharge when an ADT feed is not available.

vii. CalOptima Health and the assigned TCS manager is responsible for coordinating and verifying that Members receive all appropriate TCS, regardless of setting.

viii. CalOptima Health will ensure prior authorizations required for a Member's discharge are processed in a timely manner.

ix. CalOptima Health and the assigned Care Managers will ensure a discharge risk assessment and planning document is completed prior to discharge and shared with appropriate parties and Member.

x. Ensuring needed post-discharge services are provided, and follow-ups are scheduled, including any necessary Referrals.

xi. Members will be assessed for ECM or CCM services, risk of re-institutionalization, re-hospitalization, destabilization of a mental health condition and/or SUD relapse.

xii. End of TCS Services

a) TCS will end once the Member has been connected to all needed services including but not limited to all services that are identified in the discharge risk assessment or discharge planning document.

b) CalOptima Health will ensure Members are connected to their new care manager through Referral if the Member is enrolled in ECM or CCM, and if the care manager responsible for TCS will not continue as their ECM or CCM Lead Care Manager.

xiii. CalOptima Health will ensure delegated Health Networks follow and coordinate service.

xiv. Members who are dually eligible for Medi-Cal and Medicare enrolled in Medicare FFS or MA Plans (except D-SNPS), MCPs are responsible for all TCS requirements.

xv. Members dual eligible for Medi-Cal and Medicare and enrolled in Medicare Medi-Cal Plans (MMPs) or any other D-SNP, CalOptima Health is responsible for notifying an existing ECM or CCM care manager of the admission, discharge or transfer. CalOptima Health is not responsible for assigning a TCS care manager.

xvi. TCS services for Members requiring Behavioral Health services are provided in accordance with CalOptima Health Policy GG.1900: Behavioral Health Services.

xvii. TCS services for Members residing in Long Term Care (LTC) are provided in accordance with CalOptima Health Policy GG.1800: Authorization Process, and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B), GG.1803: Authorization Process, and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility – Adult/Pediatric, and GG,1804: Admission to, Continued Stay in, and Discharge from Out-of-Network Nursing Facility Level A (NF-A) and Level B (NF-B).

F. Key Performance Indicators (KPIs)

1. CalOptima Health will assess the implementation, operations and effectiveness of the PHM Program to understand the impact on outcomes and Health Equity over time.

2. CalOptima Health will develop Key Performance Indicators (KPI) in alignment with the DHCS PHM Program Guide requirements to continuously monitor and report on the PHM Program performance.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. Department of Health Care Services (DHCS) CalAIM: Population Health Management (PHM) Policy Guide, April 2023
C. National Committee for Quality Assurance Standards and Guidelines
D. Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)
E. CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities
F. CalOptima Health Policy GG.1116: Pediatric Prevention Services
G. CalOptima Health Policy GG.1121: Early and Periodic Screening. Diagnosis and Treatment (EPSDT) Services
H. CalOptima Health Policy GG.1130: Community Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes
I. CalOptima Health Policy GG.1201: Health Education Programs
J. CalOptima Health Policy GG.1211: Health Appraisals and Self-Management Tools
K. CalOptima Health Policy GG.1213: Community Health Worker Services
L. CalOptima Health Policy GG.1301: Comprehensive Case Management Process
M. CalOptima Health Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment
N. CalOptima Health Policy GG.1324: Seniors and Persons with Disabilities (SPD) Comprehensive Case Management
O. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services
P. CalOptima Health Policy GG.1330: Case Management – California Children's Services Program/Whole-Child Model
Q. CalOptima Health Policy GG.1353: CalAIM Enhanced Care Management Services Delivery
R. CalOptima Health Policy GG.1354: CalAIM Enhanced Care Management – Eligibility and Outreach
S. CalOptima Health Policy GG.1356: CalAIM Enhanced Care Management Administration
T. CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring
U. CalOptima Health Policy GG.1613: Initial Health Appointment
V. CalOptima Health Policy GG.1701: CalOptima Health Perinatal Support Services Program
W. CalOptima Health Policy GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)
X. CalOptima Health Policy GG.1803: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility-Adult/Pediatric
Y. CalOptima Health Policy GG.1804: Admission to, Continued Stay in, and Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)
Z. CalOptima Health Policy GG.1808: Plan of Care, Long Term Care
G. CalOptima Health Policy GG.1830: In-Home Supportive Services (IHSS) Referral Coordination Process
H. CalOptima Health Policy GG.1832: Multipurpose Senior Services Program (MSSP) MSSP Identification, Referral, and Coordination of Care Process
I. CalOptima Health Policy GG.1900: Behavioral Health Services
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Policy Guide
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-030: Initial Health Appointment

L. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-004: Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care
M. CalOptima Health Comprehensive Wellness Program for Members under Twenty-One

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
TBD	Department of Health Care Services (DHCS)	TBD

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	GG.1667	CalAIM Population Health Management Program	Medi-Cal

IX. GLOSSARY

Term	Definition
Care Coordination	Services which are included in Basic Case Management, Complex Case Management, Comprehensive Medical Case Management Services, Person Centered Planning and Discharge Planning, and are included as part of a functioning Medical Home.
Case Management	A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.
Complex Case Management	The systematic coordination and assessment of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management.
Children with Special Health Care Needs (CSHCN)	Children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions, and who also require health care or related services of a type or amount beyond that required by children generally. The identification, assessment, treatment, and coordination of care for CSHCN shall comply with the requirements of Title 42, CFR, Sections 438.208(b)(3) and (b)(4), and 42 CFR Sections 438.208(c)(2), (c)(3), and (c)(4).
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Disease Management	A multi-disciplinary and continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions and that: 1. Supports the physician/Member relationship; 2. Emphasizes prevention of exacerbation and complications utilizing cost-effective and evidence-based practice guidelines and Member empowerment strategies such as self-management; and 3. Continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving health.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	A comprehensive and preventive child health program for individuals under the age of twenty-one (21) years. EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.

Term	Definition
Health Equity	Health equity is when everyone has the power and ability to access resources to be as healthy as possible, regardless of background and identity. Health equity is not something that a person can do for themselves alone. It requires commitment from community, healthcare organizations and governments to remove obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with a living wage, quality education and housing, safe environments, and health care.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. Community-Based Adult Services (CBAS); 2. Multipurpose Senior Services Program (MSSP) services; 3. Skilled Nursing Facility services and subacute care services; and 4. In-Home Supportive Services (IHSS).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Memorandum of Understanding (MOU)	An agreement between CalOptima Health and an external agency, which delineates responsibilities for coordinating care for Members.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Population Needs Assessment (PNA)	An evaluation which identifies Member health status and behaviors, Member health education and C&L needs, health disparities, and gaps in services related to these issues.
Primary Care	A basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. This type of care emphasizes caring for the Member's general health needs as opposed to Specialty Care Provider focusing on specific needs.

Term	Definition
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.
Referral	The process of a Provider directing a Member to another Provider for care and or services. A referral may or may not need to be authorized and the Member may be redirected to another Provider from the original requested Provider.
Risk Stratification	A systematic process for identifying and predicting Member risk levels relating to health care needs, services, and coordination.
Social Drivers of Health (SDOH)	The environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk.
Social Needs	Non-clinical needs relating to institutions or functioning of humans in society to meet basic needs such as relationships, mental health status, or the needs for food and shelter.

1

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

8. Approve New CalOptima Health Policy GG.1707: Doula Services

Contacts

Richard Pitts, Chief Medical Officer, (714) 246-8491
Marie Jeannis, RN, MSN, CCM, Executive Director, Population Health Management, (714) 246-8591

Recommended Actions

Approve new CalOptima Health Policy GG.1707: Doula Services in accordance with regulatory requirements.

Background

The Department of Health Care Services (DHCS) added doula services as a Medi-Cal benefit starting January 1, 2023. Doulas are birth workers who provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons. Doula services will be provided for CalOptima Health pregnant and postpartum members before, during, and after childbirth when recommended by a physician or other licensed practitioner of the healing arts.

Discussion

CalOptima Health establishes new policies and procedures to implement federal and state laws, programs regulations, contracts, and business practices. Additionally, CalOptima Health staff performs annual policy reviews to add or update internal policies and procedures to ensure compliance with applicable requirements. In December 2022, DHCS released All-Plan Letter (APL) 22-031: *Doula Services* with guidance for the delivery of the new benefit.

The purpose of Policy GG.1707: Doula Services is to ensure the processes and procedures for CalOptima Health doula services comply with DHCS APL 22-031. This policy describes the provision of doula services and benefit eligibility criteria. This policy also defines doula qualifications and supervision requirements, provider enrollment and credentialing provisions, and billing requirements.

Fiscal Impact

The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the Fiscal Year 2022-23 Operating Budget.

Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations, staff recommends that the CalOptima Health Board of Directors approve and adopt CalOptima Health Policy GG.1707: Doula Services for Medi-Cal members.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Policy GG.1717p Doula Services

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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Policy:	GG.1707p
Title:	**Doula Services**
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	*/s/*
Effective Date:	01/01/2023
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the eligibility criteria for CalOptima Health Doula services, identifies the qualifications for becoming a Doula provider, and provision of CalOptima Health Doula as a benefit.

II. POLICY

A. CalOptima Health and Health Networks are required to provide Doula Services for prenatal, perinatal, and postpartum Members when it recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law.

B. CalOptima Health and Health Networks must provide Doulas with all necessary, initial, and ongoing training and resources regarding relevant services and processes, including any available services for prenatal, perinatal, and postpartum Members in accordance with CalOptima Health Policy EE.1103: Provider Network Training.

1. Training must be provided initially when a Doula is enrolled with CalOptima Health and Health Networks, as well as on an ongoing basis.

2. CalOptima Health and Health Networks are required to provide technical support in the administration of Doula Services, ensuring accountability for all service requirements contained in the Contract, and any associated guidance issued by the Department of Health Care Services (DHCS).

C. Network Providers, including those who will operate as Providers of Doula Services, are required to enroll as Medi-Cal Providers, consistent with the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-031: Doula Services, or any superseding APL, and CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners, if there is a state-level enrollment pathway for them to do so.

D. CalOptima Health and Health Networks must ensure and monitor sufficient Provider Networks within their service areas, including Doulas, in accordance with CalOptima Health Policy GG.1600: Access and Availability Standards.

1. CalOptima Health and Health Networks must make contracting available to both individual Doulas and Doula groups.

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2. CalOptima Health and Health Networks must collaborate with their network hospitals/birthing centers to ensure there are no barriers to accessing these Providers when accompanying Members for prenatal visits, labor and delivery support, and postpartum visits regardless of outcome (stillbirth, abortion, miscarriage, live birth).

E. Receiving Doula Services does not limit Members from receiving Perinatal Support Services (PSS) through Comprehensive Perinatal Service Program (CPSP) providers or Bright Steps in accordance with CalOptima Health Policy GG.1701: CalOptima Perinatal Support Services (PSS) Program.

III. PROCEDURE

A. Doula Services can be provided virtually, in accordance with CalOptima Health Policy GG.1665: Telehealth and Other Technology-Enabled Services, or in person with locations in any setting including, but not limited to, homes, office visits, hospitals, or alternative birth centers.

1. A Doula is not prohibited from providing assistive or supportive services in the home during a prenatal or postpartum visit (i.e., a Doula may help the postpartum person fold laundry while providing emotional support and offering advice on infant care).

   a. The visit must be face-to-face, and the assistive or supportive service must be incidental to Doula Services provided during the prenatal or postpartum visit.

   b. The Member cannot be billed for the assistive or supportive service.

B. The recommending physician or licensed practitioner does not need to be enrolled in Medi-Cal or be a Network Provider with CalOptima Health.

C. Initial Recommendation

1. An initial recommendation for Doula Services can be provided through:

   a. A written recommendation in the Member's record;

   b. A standing order for Doula Services by CalOptima Health or a Health Network, physician group or other group by a licensed Provider; or

   c. A standard form signed by a physician or other licensed practitioner that a Member can provide to a Doula.

2. The initial recommendation includes the following authorizations:

   a. One initial visit;

   b. Up to eight (8) additional visits that can be provided in any combination of prenatal and postpartum visits;

   c. Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion, or miscarriage; and

   d. Up to two (2) extended three (3) hour postpartum visits after the end of a pregnancy.

D. The extended three (3) hour postpartum visits provided after the end of pregnancy do not require the Member to meet additional criteria or receive a separate recommendation.

E. Doulas should work with the Member's Primary Care Provider (PCP) (if that information is available) or work with CalOptima Health or Health Networks to refer the Member to a Network Provider who is able to render the service, if a Member requests or requires pregnancy-related services that are available through Medi-Cal.

1. These Medi-Cal services include but are not limited to:

    a. Behavioral health services;

    b. Belly binding after cesarean section by clinical personnel;

    c. Clinical case coordination;

    d. Health care services related to pregnancy, birth, and the Postpartum Period;

    e. Childbirth education group classes;

    f. Comprehensive health education including orientation, assessment, and planning (Comprehensive Perinatal Services Program services);

    g. Hypnotherapy (non-specialty mental health service);

    h. Lactation consulting, group classes, and supplies in accordance with CalOptima Health Policy GG.1704: Breastfeeding Promotion;

    i. Nutrition services (assessment, counseling, and development of care plan);

    j. Transportation; and

    k. Medically appropriate Community Supports services.

F. Eligibility Criteria for Doula Services

1. To be eligible for Doula Services, and be covered under Medi-Cal managed care, a Member must be eligible for Medi-Cal, enrolled in CalOptima Health, and have a recommendation for Doula Services from a physician or other licensed practitioner of the healing arts.

2. Medi-Cal Eligibility Checks: Doulas must verify the Member's Medi-Cal eligibility for the month of service. Doulas must contact the Member's Health Network or CalOptima Health to verify eligibility.

3. Recommendation for Doula Services: A Member would meet the criteria for a recommendation for Doula Services if pregnant, or pregnant within the past year, and would either benefit from Doula Services or they request Doula Services. Doula Services can only be provided during pregnancy; labor and delivery, including stillbirth; miscarriage; abortion; and within one year of the end of a Member's pregnancy.

G. Documentation Requirements

1. Doula Services require a written recommendation by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.

2. Initial recommendations can be provided through approved methods as outlined in section III.C.1.

3. Secondary recommendations are required for additional visits during the Postpartum period.

   a. A recommendation for additional visits during the Postpartum Period cannot be established by standing order.

   b. The additional recommendation authorizes nine (9) or fewer additional postpartum visits.

4. CalOptima Health and Health Networks must ensure Doulas document the dates, time, and duration of services provided to Members.

   a. Documentation must also reflect information on the service provided and the length of time spent with the Member that day.

   b. Documentation should be integrated into the Member's medical record and available for encounter data reporting in accordance with CalOptima Health Policy EE.1111: Health Network Encounter Reporting Requirements.

   c. The Doula's National Provider Identifier (NPI) number should be included in the documentation.

5. Documentation must be accessible to CalOptima Health and DHCS upon request.

H. Doula Requirements and Qualifications

1. All Doulas must be at least eighteen (18) years old, possess an adult/infant Cardiopulmonary Resuscitation (i.e., CPR) certification, and have completed Health Insurance Portability and Accountability Act training.

2. A Doula must qualify by meeting either the training or experience pathway, as described below:

   a. Training Pathway:

      i. Complete a minimum of sixteen (16) hours of training in the following areas:

         a) Lactation support;

         b) Childbirth education;

         c) Foundations on anatomy of pregnancy and childbirth;

         d) Nonmedical comfort measures, prenatal support, and labor support techniques; and

         e) Developing a community resource list.

ii. Provide support at a minimum of three (3) births.

b. Experience Pathway:

i. All of the following:

a) At least five (5) years of active Doula experience in either a paid or volunteer capacity within the previous seven (7) years.

b) Attestation to skills in prenatal, labor, and postpartum care as demonstrated by the following: Three (3) written client testimonial letters, or professional letters of recommendation from any of the following: a physician, licensed behavioral health Provider, nurse practitioner, nurse midwife, licensed midwife, enrolled Doula, or community-based organization. Letters must be written within the last seven years. One (1) letter must be from either a licensed Provider, a community-based organization, or an enrolled Doula. "Enrolled Doula" means a Doula enrolled either through DHCS or through CalOptima Health.

c. Continuing Education:

i. CalOptima Health and Health Networks must ensure Doulas complete three (3) hours of continuing education in maternal, perinatal, and/or infant care every three (3) years.

ii. Doulas must maintain evidence of completed training to be made available to DHCS upon request.

I. Non-Covered Doula Services:

1. Doula Services do not include diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure.

2. The following services are not covered under Medi-Cal or as Doula Services:

a. Belly binding (traditional/ceremonial);

b. Birthing ceremonies (i.e., sealing, closing the bones, etc.);

c. Group classes on babywearing;

d. Massage (maternal or infant);

e. Photography;

f. Placenta encapsulation;

g. Shopping;

h. Vaginal steams; and

i. Yoga.

3. Doulas are not prohibited from teaching classes that are available at no cost to Members to whom they are providing Doula Services.

J. Billing and Payments

1. CalOptima Health and Health Networks must reimburse Doulas in accordance with their Network Provider contract, and in accordance with CalOptima Health Policies FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible, and FF.1014: Payment for Covered Services Rendered to a Member Enrolled in a Health Network.

    a. CalOptima Health and Health Networks are prohibited from establishing unreasonable or arbitrary barriers for accessing Doula Services.

2. Claims for Doula Services must be submitted with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual.

    a. Doulas cannot double bill, as applicable, for Doula Services that are duplicative to services that are reimbursed through other benefits.

3. All visits are limited to one per day, per Member. Only one (1) Doula can bill for a visit provided to the same Member on the same day, excluding labor and delivery. One (1) prenatal visit or one (1) postpartum visit can be provided on the same day as labor and delivery, stillbirth, abortion, or miscarriage support. The prenatal visit or postpartum visit billed on the same calendar day as birth can be billed by a different Doula.

4. The extended postpartum visits are billed in fifteen (15) minute increments, up to three (3) hours, up to two (2) visits per pregnancy per individual provided on separate days.

K. Monitoring

1. CalOptima Health and Health Networks must ensure that Doula Services Providers have a National Provider Identifier (NPI) and that these NPIs are entered in the 274 Network Provider File.

2. DHCS will monitor CalOptima Health's initial implementation of Doula Services and requirements through existing data reporting mechanisms such as Encounter Data, Grievances and Appeals, and the 274 Network Provider File in accordance with CalOptima Health Policy AA.1270: Certification of Document and Data Submissions.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy AA.1270: Certification of Document and Data Submissions
B. CalOptima Health Policy EE.1103: Provider Network Training
C. CalOptima Health Policy EE.1111: Health Network Encounter Reporting Requirements
D. CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible
E. CalOptima Health Policy FF.1014: Payment for Covered Services Rendered to a Member Enrolled in a Health Network
F. CalOptima Health Policy GG.1600: Access and Availability Standards
G. CalOptima Health Policy GG.1603: Medical Records Maintenance

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H. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
I. CalOptima Health Policy GG.1665: Telehealth and Other Technology-Enabled Services
J. CalOptima Health Policy GG.1701: CalOptima Perinatal Support Services (PSS) Program
K. CalOptima Health Policy GG.1704: Breastfeeding Promotion
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-031: Doula Services
N. Department of Health Care Services (DHCS) Medi-Cal Provider Manual – Doula Services
O. Title 42, Code of Federal Regulations (CFR) Section §440.130(c)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
TBD	Department of Health Care Services (DHCS)	TBD

VII. BOARD ACTION(S)

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

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2023	GG.1707p	Doula Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Community Supports	Pursuant to 42 CFR § 438.3(e)(2), Community Supports are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Authorized Community Supports offered are included in development of CalOptima Health's capitation rate and count toward the medical expense component of CalOptima Health's Medical Loss Ratio (MLR) in accordance with 42 CFR § 438.8 (e)(2) Community Supports are optional for both CalOptima Health and the Member and must be approved by DHCS.
Doula	Birth workers who provide health education, advocacy, and physical, emotional and non-medical support for pregnant and postpartum persons before, during and after childbirth (perinatal period) including support during miscarriage, stillbirth and abortion, with the goal of preventing perinatal complications and improving health outcomes for birthing parents and infants. Doulas are not licensed or clinical providers, and they do not require supervision.
Doula Services	Doula Services encompass health education, advocacy, and physical, emotional and nonmedical support provided before, during and after childbirth or end of a pregnancy, including throughout the Postpartum Period.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Network Provider	A Provider that subcontracts with CalOptima Health for the delivery of Medi-Cal Covered Services.
Postpartum Period	Doulas may provide services for up to twelve (12) months from the end of pregnancy. Beneficiaries are eligible to receive full-scope Medi-Cal coverage for at least twelve (12) months after pregnancy.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
9. Approve New CalOptima Health Policy ITS.1308p: DHCS 834 Eligibility Process

Contacts
Wael Younan, Chief Information Officer / Chief Information Security Officer, (657) 900-1154
Nora Onishi, Director, Information Technology Services, (714) 246-8630

Recommended Action
Approve new CalOptima Health Policy ITS.1308p: DHCS 834 Eligibility Process.

Background/Discussion
CalOptima Health has been processing the DHCS 834 eligibility file under Information Technology Services (ITS) Standard Operating Procedure (SOP) for the past years. The DHCS 2024 contract readiness requirements mandate that CalOptima Health's ITS SOP be defined within a policy and procedure.

Policy ITS.1308p defines the guidelines for CalOptima Health's DHCS 834 eligibility process.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the Fiscal Year 2022-23 Operating Budget.

Rationale for Recommendation
CalOptima Health staff recommends that the Board approve new policy ITS.1308p to ensure CalOptima Health's compliance with the DHCS 2024 contract requirements.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. New Policy ITS.1308p DHCS 834 Eligibility Process

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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Policy:	ITS.1308p
Title:	**DHCS 834 Eligibility Process**
Department:	Information Technology Services
Section:	ITS Applications Management - Batch Operations
CEO Approval:	*/s/*
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes CalOptima Health's process to access the Department of Health Care Services (DHCS) daily and monthly Medi-Cal enrollment eligibility files and utilize data to update CalOptima Health core Managed Care System applications with the most current Medi-Cal membership status.

II. POLICY

A. CalOptima Health shall:

1. Perform a standard daily retrieval from the DHCS File Transfer Protocol (FTP) site.

2. Create a program to stage and load the daily files to update CalOptima Health's core Managed Care System including updates to:

   a. Eligibility additions, changes, terminations, deletions, and cancellations;

   b. Member demographics; and

   c. Member attributes.

3. Create a summarized count of updates and balance check file load process.

III. PROCEDURE

A. CalOptima Health shall:

1. On a daily basis, access the DHCS FTP site at /DHCS-834ManagedCare/Plan Folders/Prod834ManagedCare/ and download the set of files into the CalOptima Health directory at: \\optima\Support\DHS_FAME834.

   a. Daily file transmission occurs once per day, Monday through Friday evening, except for established holidays.

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i. The daily set consists of five (5) files (DHCS834; CINXREF; CNTYXREF; HICXREF; HISDB)

b. On a monthly basis, access the DHCS FTP site for transmissions in accordance with the DHCS annual calendar for file transmittals. The monthly set of files consists of:

i. The new month's eligibility (as of the first of the following month) and fifteen (15) historical months including any retroactive transactions per month.

ii. The monthly set consists of six (6) files (DHCS834; CINXREF; CNTYXREF; HICXREF; HISDB; CARRIER).

2. Initiate staging process utilizing Biztalk (this step breaks down the DHCS set of files) to create data tables which sets up the load into CalOptima Health's core Managed Care System.

3. Execute batch job to load the data into CalOptima Health's core Managed Care System addressing current eligibility adds, changes, terminations, removals, and changes to Member demographics or attributes. This batch job will also address monthly retroactive activity regarding eligibility segments to update historical data.

4. Generate output files for each batch job run to create an error report from to ensure the process is completed successfully and identify any errors or failed elements that may have occurred.

a. Error reports are reviewed with the Enrollment and Reconciliation (E&R) team and are manually updated based on their review and findings.

5. Update eligibility data in CalOptima Health's core Managed Care System for distribution to the following and in accordance with scheduled frequency from external sources, where applicable.

a. All surrounding applications;

b. CalOptima Health's Data Warehouse;

c. CalOptima Health's Provider Portal;

d. CalOptima Health's Interactive Voice Response (IVR) software;

e. Health Networks;

f. Servicing partners; and

g. Primary Care Physician (PCP) providers.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

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

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
01/20/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

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

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	ITS.1308	DHCS 834 Eligibility Process	Medi-Cal Administrative

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IX. GLOSSARY

Not Applicable

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

10. Approve Updated CalOptima Health Office of Compliance Policy HH.1107

Contact

John Tanner, Chief Compliance Officer, (657) 235-6997

Recommended Actions

Approve updated Office of Compliance Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting.

Background

Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting establishes a process to investigate and report suspected fraud, waste, and abuse (FWA) committed by a CalOptima Health providers, employees, members, First-tier, Downstream or Related Party (FDR), and/or Health Networks involving a CalOptima Health program in accordance with federal and state regulations and contractual requirements.

Discussion

CalOptima Health regularly reviews its policies and procedures to ensure they are up to date and aligned with federal and state health care program requirements and standard operating procedures. The Office of Compliance updated Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting to provide further clarity around the process by which all initial reports of suspected FWA are handled within target timeframes specified in the policy. The policy update also includes clarification as to the information needed to move forward with an investigation and required reporting and how reports without sufficient information are handled. Lastly, policy updates include a statement that all reports of suspected FWA are kept confidential to the extent permitted by applicable law and circumstances.

Fiscal Impact

The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the Fiscal Year 2022-23 Operating Budget.

Rationale for Recommendation

CalOptima Health staff recommends that the Board of Directors approve and adopt the presented policy and procedure to ensure continued compliance of its operations with applicable state and federal laws and regulations.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. CalOptima Health Policy HH.1107 Fraud, Waste and Abuse Investigation and Reporting

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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Policy:	HH.1107
Title:	**Fraud, Waste, and Abuse Investigation and Reporting**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	*/s/*
Effective Date:	09/01/2004
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes a process to investigate, and report suspected Fraud, Waste, or Abuse (FWA) committed by a Member, Provider, a CalOptima Health Employee, First Tier, Downstream, and Related Entities (FDRs), and CalOptima Health's Health Networks involving a CalOptima Health program, in accordance with federal and state regulations and contractual requirements.

II. POLICY

A. CalOptima Health maintains a zero-tolerance policy toward FWA by a Member, a Provider, an Employee, an FDR and/or a Health Network.

B. CalOptima Health shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of Covered Services, which include, but are not limited to, federal and state False Claims Acts and Anti-Kickback laws, the federal Exclusion Statute, the federal Administrative Remedies Act, the federal Social Security Act laws prohibiting inducements to Members, the federal Health Insurance Portability and Accountability Act (HIPAA), and other applicable statutes.

C. CalOptima Health Employees and its FDRs are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima Health program. CalOptima Health maintains a strict policy of non-retaliation and non-retribution toward Employees and its FDRs who make such reports in good faith.

D. CalOptima Health shall establish a process for timely and reasonable investigation and reporting of suspected FWA, in accordance with this Policy.

E. CalOptima Health's Office of Compliance shall coordinate all activities associated with the investigation and reporting of suspected FWA.

F. CalOptima Health's Office of Compliance shall maintain a system for the review of suspect claims to detect and prevent FWA, in accordance with federal and state regulations, and to identify resulting overpayments for recoupment, in accordance with CalOptima Health Policies HH.5000:

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Provider Overpayment Investigation and Determination and HH.1105: Fraud, Waste and Abuse Detection.

G. CalOptima Health's Office of Compliance shall collaborate with the CalOptima Health Pharmacy Management Department, and other appropriate departments, to reduce controlled substances and opioid-related Fraud, Abuse, and misuse, as outlined in CalOptima Health Policies GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities, and MA.6104: Opioid Medication Utilization Management.

1. The CalOptima Health SIU shall investigate suspected FWA of prescription drugs, and/or controlled substances, in accordance with this Policy.

H. CalOptima Health shall coordinate and cooperate with the Department of Health Care Services (DHCS), Centers for Medicare & Medicaid (CMS), and law enforcement agencies related to any FWA investigations, or audits.

I. CalOptima Health shall conduct ~~a~~ preliminary ~~investigation~~research of any allegation of suspected FWA and shall report suspected FWA to the appropriate agency, in accordance with its contracts with DHCS and/or CMS, and this Policy. All allegations received shall be documented in a FWA tracking log within one (1) business day.

J. Upon determination of validity of the allegation, CalOptima Health shall refer suspected FWA to DHCS and/or CMS for further investigation, as appropriate.

K. CalOptima Health's Office of Compliance shall maintain a database and a uniform filing system to maintain suspected FWA referrals, including reports, investigations, and correspondence, in accordance with CalOptima Health's Compliance Program. CalOptima Health's Office of Compliance shall ensure appropriate confidentiality of case files, or other documentation relating to any investigation of a suspected FWA case.

L. CalOptima Health's Office of Compliance shall function as the liaison between CalOptima Health and DHCS, CMS, appropriate state Medical Boards, the State Board of Pharmacy, other licensing entities, law enforcement, prosecuting agencies, as appropriate, and other relevant entities.

M. CalOptima Health's Office of Compliance shall report the status and results of suspected FWA investigations to CalOptima Health's Compliance Committee, as appropriate.

N. CalOptima Health's Office of Compliance shall investigate, and report suspected FWA, in accordance with this Policy.

O. All reports of suspected FWA are kept confidential to the extent permitted by applicable law and circumstances.

III. PROCEDURE

A. Reporting FWA to CalOptima Health:

1. CalOptima Health shall provide a method for CalOptima Health Employees, FDRs, and Members to anonymously report suspected FWA to the Office of Compliance. CalOptima Health Employees and its FDRs may call the Compliance and Ethics Hotline at 1-855-507-1805 to anonymously report concerns regarding Fraud, Waste, and Abuse.

2. A CalOptima Health Employee who detects suspected FWA may also complete a Suspected Fraud or Abuse Referral Form and transmit it to the Office of Compliance.

3. An FDR with a contractual obligation to report suspected FWA shall notify CalOptima Health of suspected FWA, in accordance with the terms and conditions of its contract and this Policy.

4. Any State, Federal, and/or other Managed Care Plans referrals to CalOptima Health of potential FWA are investigated and reported to DHCS's Program Integrity Unit (PIU) and shall remain confidential, as needed.

B. Investigation of FWA:

1. ~~Upon detection of~~When a report is received concerning suspected FWA, the Office of Compliance shall ~~review~~verify the suspected activity using data from reports, including, but not limited to, the following:

   a. CalOptima Health's Compliance and Ethics Hotline, or other reporting mechanisms;

   b. Claims data history;

   c. Encounter data;

   d. Member and Provider complaints, appeals, and grievance reviews;

   e. Medical Record audits;

   f. Pharmacy data;

   g. Utilization Management reports;

   h. Provider utilization profiles;

   i. Member interviews and/or service verification surveys;

   j. Employee interviews;

   ~~k.~~ Provider and/or provider staff interviews;

   ~~j.~~l. Monitoring and auditing activities;

   ~~k.~~m. Monitoring external health care FWA cases and determining if CalOptima Health's FWA program can be strengthened with information gleaned from the case activity; and/or

   ~~l.~~n. Internal and external surveys, reviews, and audits.

2. ~~For CalOptima Health Employee conduct~~All reports of suspected FWA shall be preliminarily researched to build on the information provided in the allegation in the attempt to have sufficient data for conducting an investigation. CalOptima Health has a target goal of ten (10) business days to determine if sufficient information can be garnered for an allegation in order to conduct an investigation.

a. Information needed to begin an investigation is considered on a case-by-case basis and may include:

i. Subject name;

ii. Verifiable data;

iii. Relativity/applicability to CalOptima Health; and/or

iv. Sufficient detail to determine the allegation or the potential offender.

a) An example would be if an allegation is anonymously reported and the complainant simply states his provider committed fraud, but did not give a name of a provider, there is insufficient information to conduct an investigation.

b) If there is insufficient information to proceed with conducting an investigation, the Office of Compliance may refer it to another department, agency, or other appropriate entity, and shall document the case for tracking.

1) An example would be a member grievance (complaint) that staff at a provider's office are rude. The case would not be considered an allegation of FWA and would be forwarded to the Grievances and Appeals Resolution Services (GARS) department.

~~2.~~3. For allegations of CalOptima Health Employee's misconduct investigations that involve potential FWA, a referral to SIU should be made by the CalOptima Health staff involved in the initial Employee ~~conduct~~misconduct investigation. Each referral is considered on a case-by-case basis. The referral to SIU for Employee ~~conduct~~misconduct investigations will authorize the SIU to have primary responsibility of the Employee ~~conduct~~misconduct investigation as it relates to potential FWA.

~~3.~~4. When the FWA Investigator is able to determine the probable root cause of the suspected FWA, the information will be documented in the ~~Fraud Tracking Database~~internal case management tracking log and may be reported during the quarterly Compliance Committee meetings.

~~4.~~5. If an investigation finds no component of FWA, and the actions investigated are more appropriately classified as non-compliance, the remediation shall be handled in accordance with CalOptima Health Policies HH.2005: Corrective Actions Plans, HH.2002: Sanctions, or GA.8022: Performance and Behavior Standards.

~~5.~~6. CalOptima Health shall issue corrective actions to Employees and its FDRs related to validated instances of FWA. Corrective actions will be monitored by the Compliance Committee, or the Human Resources Department, as appropriate. Corrective actions may include financial sanctions, regulatory reporting, performance improvement plans, or termination. If the validated instance of FWA is determined to be criminal in nature, actions may also include a referral to law enforcement.

~~6.~~7. The Office of Compliance will initiate review and discussion at the first Compliance Committee Meeting following the date when ~~the alleged FWA has been investigated and yielded findings~~significant instances of FWA are identified.

~~7.~~8. If CalOptima Health's SIU investigation yields findings involving an FDR, the SIU shall notify the impacted CalOptima Health department(s~~) and the~~), CalOptima Health~~,~~ Health Network(s~~).~~), and/or business partners, as needed.

~~8.~~9. For investigations involving suspected FWA of prescription drugs, including controlled substances, the CalOptima Health SIU will collaborate with the CalOptima Health Pharmacy Management Department during the investigation. If the investigation yields findings related to FWA, the SIU will work with Pharmacy Management and Quality Improvement to implement actions in accordance with CalOptima Health Policies ~~GG.1408~~MA.5013: Pharmacy Audits and Reviews, GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities, GG.1615: Corrective Action Plan for Practitioners, and MA.6104: Opioid Medication Utilization Management.

~~9.~~10. The SIU shall enter all documentation related to any suspected FWA case into the ~~Fraud Tracking Database as soon as practicable~~internal case management tracking log within one (1) business day and document the final disposition ~~as soon as practicable,~~ once the case has been determined to be closed.

C. Notices of a Credible Allegation of Fraud

1. For investigations involving situations when DHCS and/or CMS notifies CalOptima Health that a Credible Allegation of Fraud has been found against an FDR or Provider, CalOptima Health must take one (1) or more of the following options and submit any supporting documentation as requested or appropriate to DHCS and/or CMS:

   a. Terminate the FDR or Provider from its network;

   b. Temporarily suspend the FDR or Provider from its network pending resolution of the Fraud allegation;

   c. Temporarily suspend payment to the FDR or Provider pending resolution of the Fraud allegation; and/or

   d. Conduct additional monitoring including audits of the FDR's or Provider's claims history and future claims submissions for appropriate billing.

2. For investigations involving situations when there is a Credible Allegation of Fraud against a pharmacy, CalOptima Health shall work with the PBM and/or appropriate regulatory agency to take one or more of the options above.

D. Reports of changes to a Member's circumstances which may impact a Member's Medi-Cal eligibility are promptly reported to DHCS and/or the local Social Service Agency, as needed.

E. CalOptima Health Reporting to Regulators:

1. For investigations involving Medi-Cal, CalOptima Health shall report to DHCS PIU all cases of suspected Fraud and/or Abuse where there is reason to believe that an incident of Fraud and/or Abuse has occurred by CalOptima Health Employees, FDRs, or Members. CalOptima Health shall conduct, complete and report to DHCS, the results of a preliminary investigation of the

suspected Fraud and/or Abuse within ten (10) business days of the date CalOptima Health first became aware of, or is on notice of, such activity.

2. For investigations involving OneCare or PACE programs, CalOptima Health shall report to DHCS PIU in accordance with Section III.D.1. above, as well as to CMS National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) all cases of suspected Fraud and/or Abuse where there is reason to believe that an incident of Fraud and/or Abuse has occurred by CalOptima Health Employees, FDRs, or Members. CalOptima Health shall conduct a preliminary investigation and report to ~~CMS~~the NBI MEDIC within thirty (30) ~~business~~calendar days of the date potential Fraudulent or abusive activity is identified.

~~3. Referrals to DHCS and CMS, where Special Investigation Unit (SIU) detection activities result in a reason to believe suspected Fraud or Abuse has occurred and requires further investigation, shall include at a minimum:~~

~~a. Identifying information of the subject;~~

~~b. Source of complaint;~~

~~c. Type of Provider;~~

~~d. Nature of complaint;~~

~~e. Approximate dollars involved if known; and~~

~~Legal and administrative disposition of the case.~~

~~4.~~3. For investigations involving the Medi-Cal program, the referral shall be submitted on a Medi-Cal Complaint Report (MC609) that can be sent to DHCS PIU via secure email~~, secure facsimile, Federal Express with a tracking number, or certified mail.~~ . Any completed investigations and quarterly FWA reports will be made to the DHCS PIU via secure email~~, secure facsimile, Federal Express with a tracking number, or certified mail~~.

~~5.~~4. For investigations involving the OneCare or PACE programs, the referral shall be submitted ~~on a Part D/I MEDIC Complaint form that can be sent to CMS contractor or~~ via the CMS program integrity web-based portal. For investigations involving OneCare or PACE program where the allegation is exclusively a compromised identification, the referral to CMS shall be submitted on ~~a~~an I MEDIC ID Compromised ID Report Form via secure email, secure facsimile, Federal Express with a tracking number, or certified mail. CalOptima Health shall submit applicable police reports, investigation documentation (background, interviews, etc.), Member information, Provider enrollment data, confirmation of services, list items or services furnished by Provider, pharmaceutical data, and any other pertinent information.

IV. ATTACHMENT(S)

A. Suspected Fraud or Abuse Referral Form (English)
B. Form MC609 - Confidential Medi-Cal Complaint Report form
C. CalOptima Health Referral to MEDIC
D. CalOptima Health Referral to MEDIC ID Compromised

V. REFERENCE(S)

A. California Government Code, §12650, California False Claims Act
B. CalOptima Health Compliance Plan
C. CalOptima Health Contract for Health Care Services
D. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
E. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Health PACE Program Agreement
G. CalOptima Health Policy GA.8022: Performance and Behavior Standards
H. CalOptima Health Policy GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
I. CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners
~~H.~~J. CalOptima Health Policy HH.1105: Fraud, Waste, and Abuse Detection
~~I.~~K. CalOptima Health Policy HH.2002: Sanctions
~~J.~~L. CalOptima Health Policy HH.2005: Corrective Action Plan
~~K.~~M. CalOptima Health Policy HH.5000: Provider Overpayment Investigation and Determination
~~L. GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities~~
~~M.~~ CalOptima Health Policy ~~GG.1408~~MA.5013: Pharmacy Audits and Reviews
N. ~~GG.1615: Corrective Action Plan for Practitioners~~
O. CalOptima Health Policy MA.6104: Opioid Medication Utilization Management
~~P. Department of Health Care Services All Plan Letter (APL) 19-012: Federal Drugs Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse~~
~~Q.~~P. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-026: Actions Required Following Notice of a Credible Allegation of Fraud
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-012: Federal Drugs Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse
R. Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 03-011: Fraud Referral Procedure to Audits and Investigations (A&I)
S. Medicare Managed Care Manual, Chapters 9 and 21
T. Title 31, United States Code, §3730(h), Civil actions for ~~False Claims Act complaints~~false claims
U. Title 42, Code of Federal Regulations, §455.2
V. Welfare and Institutions Code, §14043.1(a)
W. 2022 CMS Part C and D Final Rule

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/01/2016	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2004	HH.1107	Fraud and Abuse Investigation and Reporting	Medi-Cal
Effective	01/01/2007	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	01/01/2008	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	09/01/2008	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	12/01/2009	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2010	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	02/01/2013	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	02/01/2013	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	07/01/2014	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2014	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare OneCare Connect
Revised	09/01/2015	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	09/01/2015	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare OneCare Connect PACE
Revised	06/01/2016	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal
Retired	12/01/2016	MA.9108	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/01/2016	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2018	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	12/06/2018	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare PACE
Revised	TBD	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in unnecessary costs to a CalOptima Health Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the Provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from Fraud, because the distinction between "Fraud" and "Abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out 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.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima Health to promote, monitor and ensure that CalOptima Health's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Covered Service	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima Health's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), or other services as authorized by the CalOptima Health Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.

Term	Definition
	OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract. PACE: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS PACE Contract with CalOptima Health, or other services as authorized by the CalOptima Health Board of Directors.
Credible Allegation of Fraud	A Credible Allegation of Fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following: (1) Fraud hotline complaints. (2) Claims data mining. (3) Patterns identified through Provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability, and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.
Employee	For purposes of this policy, any and all Employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary Employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted Providers, Health Networks, Physician Medical Groups, Physician Hospital Consortiums, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or Fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.

Term	Definition
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: 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. PACE: 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.
Medical Record	Medi-Cal: Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima Health policy. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Member	A beneficiary enrolled in a CalOptima Health Program.
Pharmacy Benefit Manager (PBM)	An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient Compliance Programs; performing drug utilization review; and operating disease management programs.

Term	Definition
Provider	Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. 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.
Related Entity	Any entity that is related to CalOptima Health by common ownership or control and that: performs some of CalOptima Health's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima Health at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy:	HH.1107
Title:	**Fraud, Waste, and Abuse Investigation and Reporting**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	*/s/*
Effective Date:	09/01/2004
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes a process to investigate, and report suspected Fraud, Waste, or Abuse (FWA) committed by a Member, Provider, a CalOptima Health Employee, First Tier, Downstream, and Related Entities (FDRs), and CalOptima Health's Health Networks involving a CalOptima Health program, in accordance with federal and state regulations and contractual requirements.

II. POLICY

A. CalOptima Health maintains a zero-tolerance policy toward FWA by a Member, a Provider, an Employee, an FDR and/or a Health Network.

B. CalOptima Health shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of Covered Services, which include, but are not limited to, federal and state False Claims Acts and Anti-Kickback laws, the federal Exclusion Statute, the federal Administrative Remedies Act, the federal Social Security Act laws prohibiting inducements to Members, the federal Health Insurance Portability and Accountability Act (HIPAA), and other applicable statutes.

C. CalOptima Health Employees and its FDRs are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima Health program. CalOptima Health maintains a strict policy of non-retaliation and non-retribution toward Employees and its FDRs who make such reports in good faith.

D. CalOptima Health shall establish a process for timely and reasonable investigation and reporting of suspected FWA, in accordance with this Policy.

E. CalOptima Health's Office of Compliance shall coordinate all activities associated with the investigation and reporting of suspected FWA.

F. CalOptima Health's Office of Compliance shall maintain a system for the review of suspect claims to detect and prevent FWA, in accordance with federal and state regulations, and to identify resulting overpayments for recoupment, in accordance with CalOptima Health Policies HH.5000:

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Provider Overpayment Investigation and Determination and HH.1105: Fraud, Waste and Abuse Detection.

G. CalOptima Health's Office of Compliance shall collaborate with the CalOptima Health Pharmacy Management Department, and other appropriate departments, to reduce controlled substances and opioid-related Fraud, Abuse, and misuse, as outlined in CalOptima Health Policies GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities, and MA.6104: Opioid Medication Utilization Management.

1. The CalOptima Health SIU shall investigate suspected FWA of prescription drugs, and/or controlled substances, in accordance with this Policy.

H. CalOptima Health shall coordinate and cooperate with the Department of Health Care Services (DHCS), Centers for Medicare & Medicaid (CMS), and law enforcement agencies related to any FWA investigations, or audits.

I. CalOptima Health shall conduct preliminary research of any allegation of suspected FWA and shall report suspected FWA to the appropriate agency, in accordance with its contracts with DHCS and/or CMS, and this Policy. All allegations received shall be documented in a FWA tracking log within one (1) business day.

J. Upon determination of validity of the allegation, CalOptima Health shall refer suspected FWA to DHCS and/or CMS for further investigation, as appropriate.

K. CalOptima Health's Office of Compliance shall maintain a database and a uniform filing system to maintain suspected FWA referrals, including reports, investigations, and correspondence, in accordance with CalOptima Health's Compliance Program. CalOptima Health's Office of Compliance shall ensure appropriate confidentiality of case files, or other documentation relating to any investigation of a suspected FWA case.

L. CalOptima Health's Office of Compliance shall function as the liaison between CalOptima Health and DHCS, CMS, appropriate state Medical Boards, the State Board of Pharmacy, other licensing entities, law enforcement, prosecuting agencies, as appropriate, and other relevant entities.

M. CalOptima Health's Office of Compliance shall report the status and results of suspected FWA investigations to CalOptima Health's Compliance Committee, as appropriate.

N. CalOptima Health's Office of Compliance shall investigate, and report suspected FWA, in accordance with this Policy.

O. All reports of suspected FWA are kept confidential to the extent permitted by applicable law and circumstances.

III. PROCEDURE

A. Reporting FWA to CalOptima Health:

1. CalOptima Health shall provide a method for CalOptima Health Employees, FDRs, and Members to anonymously report suspected FWA to the Office of Compliance. CalOptima Health Employees and its FDRs may call the Compliance and Ethics Hotline at 1-855-507-1805 to anonymously report concerns regarding Fraud, Waste, and Abuse.

2. A CalOptima Health Employee who detects suspected FWA may also complete a Suspected Fraud or Abuse Referral Form and transmit it to the Office of Compliance.

3. An FDR with a contractual obligation to report suspected FWA shall notify CalOptima Health of suspected FWA, in accordance with the terms and conditions of its contract and this Policy.

4. Any State, Federal, and/or other Managed Care Plans referrals to CalOptima Health of potential FWA are investigated and reported to DHCS's Program Integrity Unit (PIU) and shall remain confidential, as needed.

B. Investigation of FWA:

1. When a report is received concerning suspected FWA, the Office of Compliance shall verify the suspected activity using data from reports, including, but not limited to, the following:

   a. CalOptima Health's Compliance and Ethics Hotline, or other reporting mechanisms;

   b. Claims data history;

   c. Encounter data;

   d. Member and Provider complaints, appeals, and grievance reviews;

   e. Medical Record audits;

   f. Pharmacy data;

   g. Utilization Management reports;

   h. Provider utilization profiles;

   i. Member interviews and/or service verification surveys;

   j. Employee interviews;

   k. Provider and/or provider staff interviews;

   l. Monitoring and auditing activities;

   m. Monitoring external health care FWA cases and determining if CalOptima Health's FWA program can be strengthened with information gleaned from the case activity; and/or

   n. Internal and external surveys, reviews, and audits.

2. All reports of suspected FWA shall be preliminarily researched to build on the information provided in the allegation in the attempt to have sufficient data for conducting an investigation. CalOptima Health has a target goal of ten (10) business days to determine if sufficient information can be garnered for an allegation in order to conduct an investigation.

a. Information needed to begin an investigation is considered on a case-by-case basis and may include:

i. Subject name;

ii. Verifiable data;

iii. Relativity/applicability to CalOptima Health; and/or

iv. Sufficient detail to determine the allegation or the potential offender.

a) An example would be if an allegation is anonymously reported and the complainant simply states his provider committed fraud, but did not give a name of a provider, there is insufficient information to conduct an investigation.

b) If there is insufficient information to proceed with conducting an investigation, the Office of Compliance may refer it to another department, agency, or other appropriate entity, and shall document the case for tracking.

1) An example would be a member grievance (complaint) that staff at a provider's office are rude. The case would not be considered an allegation of FWA and would be forwarded to the Grievances and Appeals Resolution Services (GARS) department.

3. For allegations of CalOptima Health Employee's misconduct investigations that involve potential FWA, a referral to SIU should be made by the CalOptima Health staff involved in the initial Employee misconduct investigation. Each referral is considered on a case-by-case basis. The referral to SIU for Employee misconduct investigations will authorize the SIU to have primary responsibility of the Employee misconduct investigation as it relates to potential FWA.

4. When the FWA Investigator is able to determine the probable root cause of the suspected FWA, the information will be documented in the internal case management tracking log and may be reported during the quarterly Compliance Committee meetings.

5. If an investigation finds no component of FWA, and the actions investigated are more appropriately classified as non-compliance, the remediation shall be handled in accordance with CalOptima Health Policies HH.2005: Corrective Actions Plans, HH.2002: Sanctions, or GA.8022: Performance and Behavior Standards.

6. CalOptima Health shall issue corrective actions to Employees and its FDRs related to validated instances of FWA. Corrective actions will be monitored by the Compliance Committee, or the Human Resources Department, as appropriate. Corrective actions may include financial sanctions, regulatory reporting, performance improvement plans, or termination. If the validated instance of FWA is determined to be criminal in nature, actions may also include a referral to law enforcement.

7. The Office of Compliance will initiate review and discussion at the first Compliance Committee Meeting following the date when significant instances of FWA are identified.

8. If CalOptima Health's SIU investigation yields findings involving an FDR, the SIU shall notify the impacted CalOptima Health department(s), CalOptima Health Health Network(s), and/or business partners, as needed.

9. For investigations involving suspected FWA of prescription drugs, including controlled substances, the CalOptima Health SIU will collaborate with the CalOptima Health Pharmacy Management Department during the investigation. If the investigation yields findings related to FWA, the SIU will work with Pharmacy Management and Quality Improvement to implement actions in accordance with CalOptima Health Policies MA.5013: Pharmacy Audits and Reviews, GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities, GG.1615: Corrective Action Plan for Practitioners, and MA.6104: Opioid Medication Utilization Management.

10. The SIU shall enter all documentation related to any suspected FWA case into the internal case management tracking log within one (1) business day and document the final disposition once the case has been determined to be closed.

C. Notices of a Credible Allegation of Fraud

1. For investigations involving situations when DHCS and/or CMS notifies CalOptima Health that a Credible Allegation of Fraud has been found against an FDR or Provider, CalOptima Health must take one (1) or more of the following options and submit any supporting documentation as requested or appropriate to DHCS and/or CMS:

   a. Terminate the FDR or Provider from its network;

   b. Temporarily suspend the FDR or Provider from its network pending resolution of the Fraud allegation;

   c. Temporarily suspend payment to the FDR or Provider pending resolution of the Fraud allegation; and/or

   d. Conduct additional monitoring including audits of the FDR's or Provider's claims history and future claims submissions for appropriate billing.

2. For investigations involving situations when there is a Credible Allegation of Fraud against a pharmacy, CalOptima Health shall work with the PBM and/or appropriate regulatory agency to take one or more of the options above.

D. Reports of changes to a Member's circumstances which may impact a Member's Medi-Cal eligibility are promptly reported to DHCS and/or the local Social Service Agency, as needed.

E. CalOptima Health Reporting to Regulators:

1. For investigations involving Medi-Cal, CalOptima Health shall report to DHCS PIU all cases of suspected Fraud and/or Abuse where there is reason to believe that an incident of Fraud and/or Abuse has occurred by CalOptima Health Employees, FDRs, or Members. CalOptima Health shall conduct, complete and report to DHCS, the results of a preliminary investigation of the suspected Fraud and/or Abuse within ten (10) business days of the date CalOptima Health first became aware of, or is on notice of, such activity.

2. For investigations involving OneCare or PACE programs, CalOptima Health shall report to DHCS PIU in accordance with Section III.D.1. above, as well as to CMS National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) all cases of suspected Fraud and/or Abuse where there is reason to believe that an incident of Fraud and/or Abuse has occurred by CalOptima Health Employees, FDRs, or Members. CalOptima Health shall conduct a preliminary investigation and report to the NBI MEDIC within thirty (30) calendar days of the date potential Fraudulent or abusive activity is identified.

3. For investigations involving the Medi-Cal program, the referral shall be submitted on a Medi-Cal Complaint Report (MC609) that can be sent to DHCS PIU via secure email. Any completed investigations and quarterly FWA reports will be made to the DHCS PIU via secure email.

4. For investigations involving the OneCare or PACE programs, the referral shall be submitted via the CMS program integrity web-based portal. For investigations involving OneCare or PACE program where the allegation is exclusively a compromised identification, the referral to CMS shall be submitted on an I MEDIC ID Compromised ID Report Form via secure email, secure facsimile, Federal Express with a tracking number, or certified mail. CalOptima Health shall submit applicable police reports, investigation documentation (background, interviews, etc.), Member information, Provider enrollment data, confirmation of services, list items or services furnished by Provider, pharmaceutical data, and any other pertinent information.

IV. ATTACHMENT(S)

A. Suspected Fraud or Abuse Referral Form (English)
B. Form MC609 - Confidential Medi-Cal Complaint Report form
C. CalOptima Health Referral to MEDIC
D. CalOptima Health Referral to MEDIC ID Compromised

V. REFERENCE(S)

A. California Government Code, §12650, California False Claims Act
B. CalOptima Health Compliance Plan
C. CalOptima Health Contract for Health Care Services
D. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
E. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Health PACE Program Agreement
G. CalOptima Health Policy GA.8022: Performance and Behavior Standards
H. CalOptima Health Policy GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
I. CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners
J. CalOptima Health Policy HH.1105: Fraud, Waste, and Abuse Detection
K. CalOptima Health Policy HH.2002: Sanctions
L. CalOptima Health Policy HH.2005: Corrective Action Plan
M. CalOptima Health Policy HH.5000: Provider Overpayment Investigation and Determination
N. CalOptima Health Policy MA.5013: Pharmacy Audits and Reviews
O. CalOptima Health Policy MA.6104: Opioid Medication Utilization Management
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-026: Actions Required Following Notice of a Credible Allegation of Fraud
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-012: Federal Drugs Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse

R. Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 03-011: Fraud Referral Procedure to Audits and Investigations (A&I)
S. Medicare Managed Care Manual, Chapters 9 and 21
T. Title 31, United States Code, §3730(h), Civil actions for false claims
U. Title 42, Code of Federal Regulations, §455.2
V. Welfare and Institutions Code, §14043.1(a)
W. 2022 CMS Part C and D Final Rule

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/01/2016	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2004	HH.1107	Fraud and Abuse Investigation and Reporting	Medi-Cal
Effective	01/01/2007	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	01/01/2008	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	09/01/2008	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	12/01/2009	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2010	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	02/01/2013	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	02/01/2013	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	07/01/2014	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2014	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare OneCare Connect
Revised	09/01/2015	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2015	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare OneCare Connect PACE
Revised	06/01/2016	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal
Retired	12/01/2016	MA.9108	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/01/2016	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2018	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare PACE
Revised	TBD	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in unnecessary costs to a CalOptima Health Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the Provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from Fraud, because the distinction between "Fraud" and "Abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out 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.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima Health to promote, monitor and ensure that CalOptima Health's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Covered Service	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima Health's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), or other services as authorized by the CalOptima Health Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.

Term	Definition
	OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract. PACE: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS PACE Contract with CalOptima Health, or other services as authorized by the CalOptima Health Board of Directors.
Credible Allegation of Fraud	A Credible Allegation of Fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following: (1) Fraud hotline complaints. (2) Claims data mining. (3) Patterns identified through Provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability, and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.
Employee	For purposes of this policy, any and all Employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary Employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted Providers, Health Networks, Physician Medical Groups, Physician Hospital Consortiums, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or Fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.

Term	Definition
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: 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. PACE: 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.
Medical Record	Medi-Cal: Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima Health policy. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Member	A beneficiary enrolled in a CalOptima Health Program.
Pharmacy Benefit Manager (PBM)	An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient Compliance Programs; performing drug utilization review; and operating disease management programs.

Term	Definition
Provider	Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. 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.
Related Entity	Any entity that is related to CalOptima Health by common ownership or control and that: performs some of CalOptima Health's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima Health at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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CONFIDENTIAL

CalOptima Health

INSTRUCTIONS FOR COMPLETING A
SUSPECTED FRAUD OR ABUSE REFERRAL FORM

To submit a request to investigate suspected fraud or abuse, please complete a CalOptima Health Suspected Fraud or Abuse Referral Form. Examples of "Member" or "Provider" fraud or abuse are listed on the form. These are examples only. The list does not represent every situation in which fraud or abuse can take place.

Complete all applicable sections of the form. It is very important to complete the entire form so we can effectively investigate the issue.

If desired, requestor may remain anonymous; however, if the requestor does not provide his/her name and phone number, the CalOptima Health Office of Compliance will be unable to contact him/her if there are any questions about the information submitted, which may prevent completion of the investigation.

Submit the completed form with supporting documents to CalOptima Health's Office of Compliance via one
of the following methods:

1. Email: Fraud@CalOptima.org
2. U.S. Mail: CalOptima Health
   Office of Compliance — SIU
   505 City Parkway West
   Orange, CA 92868
3. Fax: **1-714-481-6457**

MARK ALL CORRESPONDENCE AS "CONFIDENTIAL."

You may also report suspected fraud or abuse to CalOptima Health's Ethics and Compliance hotline,
24 hours a day, 7 days a week, toll-free at 1-855-507-1805. TDD/TTY users can call toll-free at 1-800-735-2929. We have staff that speak your language.

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CalOptima Health

SUSPECTED FRAUD OR ABUSE REFERRAL FORM

REFERRAL INFORMATION		
Date: _____		Notice involves suspected fraud or abuse by a:
Referred by: Name: _____	Title: _____	☐ Member
Dept.: _____	Phone#: _____	☐ Provider

MEMBER	PROVIDER
CalOptima Health Program: ☐ Medi-Cal ☐ OneCare ☐ PACE	Provider Name:
Member Name:	Type of provider:
Member ID:	Provider ID #:
Address:	Address:
City: ZIP:	City: ZIP:
Date of service if applicable:	Date of service if applicable:
Member ID, if applicable:	If multiple members are involved, please attach a list.

Examples of suspected fraud or abuse:

- ☐ Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services and prescriptions (unless that person is an authorized representative who is presenting such information to obtain covered services on behalf of a member)
- ☐ Selling, loaning or giving a member's identity or documentation of eligibility to obtain covered services (other than to a family member to obtain covered services on behalf of a member)
- ☐ Falsely claiming eligibility
- ☐ Using a covered service for purposes other than the purposes for which it was prescribed, including use by an individual other than the member for whom the covered service was prescribed or provided
- ☐ Failing to report other health coverage
- ☐ Soliciting or receiving a kickback, bribe or rebate as an inducement to receive or not receive covered services
- ☐ Other (please specify) _____

Allegation of suspected fraud or abuse:

- ☐ Falsely claiming eligibility to participate in the CalOptima Health program.
- ☐ Submission of claims for covered services that are:
  - ☐ Substantially and demonstrably more than any individual's usual charges for such covered services
  - ☐ Not actually provided to the member for which the claim is submitted
  - ☐ More than the quantity that is medically necessary
  - ☐ Billed using a code that would result in greater payment than the code that reflects the covered service
  - ☐ Already included in capitation rate
  - ☐ Submitted for payment to both CalOptima Health and another third-party payer without full disclosure

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CalOptima Health

SUSPECTED FRAUD OR ABUSE REFERRAL FORM

	☐ Charging a member in excess of allowable co-payments and deductibles for covered services ☐ Billing a member for covered services without obtaining written consent to bill for such services ☐ Failure to disclose conflict of interest ☐ Receiving, soliciting or offering a kickback, bribe or rebate to refer or fail to refer a member ☐ Failure to register billing intermediary with the Department of Health Care Services (DHCS) ☐ False certification of medical necessity ☐ Attributing a diagnosis code to a member that does not reflect the member's medical condition to obtain higher reimbursement ☐ False or inaccurate Minimum Standards or credentialing information ☐ Submitting reports that contain unsubstantiated data, data that is inconsistent with records or has been altered in a manner that is inconsistent with policies, contracts, statutes or regulations. ☐ Other (please specify) _____

DOCUMENTATION (PLEASE ATTACH):

☐ Claims data ☐ Medical records ☐ Complaint, appeal or grievance ☐ UM reports
☐ Audit ☐ Other (please specify) _____

Please provide a brief explanation of how the documentation provided supports concerns of fraudulent activity: _____

Please provide the root cause of this suspected fraudulent activity: _____

OTHER RELEVANT INFORMATION (PLEASE ATTACH):

Are there any prior suspected fraud or abuse issues by this member, provider, pharmacy, other: _____

1. ☐ No
   ☐ Yes. Please describe:

2. If yes, what was the outcome?

Please submit this form with all pertinent documentation to the OFFICE OF COMPLIANCE SPECIAL INVESTIGATIONS UNIT (SIU). The Office of Compliance SIU shall report as appropriate to local and state entities.

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SUSPECTED FRAUD OR ABUSE REFERRAL FORM

If you do not receive an acknowledgement of receipt of this form within five (5) working days, please send an email to Fraud@CalOptima.org.

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MEDI-CAL COMPLAINT REPORT

GENERAL INTAKE INFORMATION - Agency Receiving Complaint		
☐ DHCS ☐ County ☐ Other (specify)		
Name of Staff Taking Complaint:	Title:	
Agency Name (if other than DHCS):	Address if other than DHCS:	
Telephone Number:	Email:	
How complaint was received:	Time & Date received:	Type of complaint: ☐ Provider ☐ Recipient ☐ Drug ☐ IHSS ☐ Other

COMPLAINANT INFORMATION		
Name of Person Reporting Complaint:	Email:	Phone:
Address:	City & Zip:	

SUBJECT INFORMATION		
Subject Name:	Address:	City & Zip:
Subject Phone Number:	Email:	

Recipient Name:	Social Security Number:	Date of Birth:
Address: (Number, Street)	City & Zip	Phone:
Provider Name & DBA:	NPI, Provider Number, or SSN	Date of Birth:(IHSS)
Address: (number, street)	City, State	Phone:
Relationship to recipient:(IHSS)	Other information:	

NATURE OF COMPLAINT:

(Attach additional sheets if necessary)

COMPLAINT PROCESSED FOR INVESTIGATION: (For DHCS IB Use Only)		
Possible Statute, Regulation, Policy, Or Code Violation:	Code Description:	Open Date:
	Date Assigned by PAU:	PAU Internal Tracking Number:
☐ Supporting Documents	Case Number:	
☐ Credible Allegation of Fraud	Supervisor Assigned:	Date:
☐ Est. Medi-Cal Program Loss:	Investigator Assigned:	Date:
☐ Referral to DOJ Date:	☐ Referral to other Agency:	Date:

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Qlarant

Investigations MEDIC Complaint Form

Instruction: The purpose of this form is to report complaints of fraud, waste, and abuse in the Medicare Parts C & D Programs. A representative from Qlarant may contact you upon receipt of this complaint, so please be sure to furnish sufficient contact information. **Please enter description of findings/allegations on next page.**

Date of Referral: _____

Please designate as a Part C or Part D issue:

- ◯ Medicare Advantage Issue (Part C)
- ◯ Prescription Drug Benefit Issue (Part D)
- ◯ Both Part C and Part D Issue

Complainant Contact Information:

Name: _____ Phone: _____ Fax: _____

Email: _____

Submitted By (Select One) ◯ Plan ◯ PBM ◯ UPIC ◯ Other on behalf of (if applicable):

_____

Complainant Organization Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Plan Name/Contract # (if applicable): _____

Plan Tracking # (if applicable): _____

Parent Organization (if applicable): _____

Pharmacy Benefit Manager (if applicable): _____

Beneficiary Information:

Name: _____ Phone: _____

HICN#: _____ MBI #: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Primary language (if other than English): _____

Medicare Plan Name: _____ Member ID#: _____

Is the Beneficiary a Subject? ◯ No ◯ Yes ◯ Unknown

Do you have any Contact Reports on the beneficiary? ◯ No ◯ Yes ◯ Unknown

To ensure compliance with all applicable laws, do not send Protected Health Information (PHI) via email.

Please fax this form to 410-819-8698, email to I-MEDICComplaints@qlarant.com, call 877-7SAFERX, or mail to Qlarant, Inc., 28464 Marlboro Avenue, Easton, MD 21601-2732, Attn: I-MEDIC

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Qlarant

Investigations MEDIC Complaint Form

Description of Subject/Suspects of Fraud:

Name: _____ Tax ID (TIN): _____ NPI: _____

DEA#: _____ Medicare Provider #: _____

Business (DBA): _____ Phone#: _____

Address: _____ City: _____ State: _____ Zip: _____

Please describe type of business or physician specialty: _____

Complaint Details:

Prior MEDIC Case Number (if applicable): _____

Period of Review: _____

Potential **MEDICARE** program exposure:

Part C program exposure: Billed $ Paid $

Part D program exposure: Billed $ Paid $

Was this matter forwarded to Law Enforcement?

○ No ○ Yes If yes, type: ○ OIG ○ FBI ○ Local

Was PLATO used? ○ No ○ Yes

Did you receive Medical Records? ○ No ○ Yes

If yes, have you completed a Medical Record Review? ○ No ○ Yes

Have you reported Patient Harm in this matter to another agency? ○ No ○ Yes

Description of Findings/Allegations: (Please provide a detailed description of the nature of the fraud issue including the following: description of fraudulent activity; CPT codes involved; states where the fraud activity took place; description of individuals and/or businesses involved in the alleged illegal activity; dates that the fraud occurred; names and contact information for victims; and copies of documentation regarding the fraudulent activity including letters, advertising, etc.):

To ensure compliance with all applicable laws, do not send Protected Health Information (PHI) via email.

Please fax this form to 410-819-8698, email to I-MEDICComplaints@qlarant.com, call 877-7SAFERX, or mail to Qlarant, Inc., 28464 Marlboro Avenue, Easton, MD 21601-2732, Attn: I-MEDIC

I-MEDIC Compromised ID Report Form

Instructions: The purpose of this form is to report compromised Health Insurance Claim Numbers (HICNs), and/or Medicare Beneficiary Identifiers (MBIs); prescribing provider identifiers, or dispensing provider identifiers in the Medicare Parts C & D programs. Qlarant may contact you upon receipt of this report, so please be sure to furnish sufficient contact information. Please supply one compromised subject per form. To ensure compliance with all applicable laws, please do not send Protected Health Information (PHI) via email.

Please fax this form to 410-819-8698, Attn: Qlarant, Investigations MEDIC, Complaints Manager, or email it as an encrypted attachment to I-MEDICComplaints@qlarant.com.

Submitter Contact Information

Name: _____ Phone: _____ Fax: _____

Organization: _____ Email: _____

Address: _____ City: _____State: _____ Zip:_____

Compromised ID Information:

Type of entity: ◯ Beneficiary ◯ Prescriber/Provider ◯ Pharmacy

Description of Identifier which has been compromised (e.g. HICN, MBI, DEA NPI, NCPDP):

Identifier(s) which has been compromised:

Name of entity or individual:

Address of entity or individual: City: State:

Type of issue: ◯ Part C Issue ◯ Part D Issue ◯ Part C and D Issue

Report Details:

Please provide any information regarding how the number was compromised, subjects involved, etc. This may include a description of how the theft occurred, dates that the fraud occurred, description of individuals and/or businesses involved in the alleged activity, names and contact information for victims, and copies of documentation regarding the fraudulent activity including letters, advertising, attestations, affidavits, verification forms, etc. (enter details on page 2).

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

11. Approve Actions Related to an Existing Contract for Zscaler to Include Zero Trust Network Architecture.

Contacts

Wael Younan, Chief Information Officer / Chief Information Security Officer, (657) 900-1154
James Steele, Senior Director, Information Security, (714) 497-6046

Recommended Actions

1. Approve migration from the existing Zscaler product level to the Zscaler Transformation edition that includes Zero Trust Network Architect (ZTNA) capabilities.

Background

As part of CalOptima Health's Workplace Modernization and Digital Transformation Strategy, Information Technology Services (ITS) will be evaluating and deploying multiple solutions. These solutions coincide with CalOptima Health's Cloud First strategy and take regulatory compliance and security measures into consideration. These initiatives will assist CalOptima Health in achieving its vision statement of removing barriers to achieve real-time claims payments and 24-hour treatment authorizations and doing annual assessments around social determinants of health by 2027. The projects and products that CalOptima Health implements will result in value-based care and improvements for member, provider, and employee experiences. These enhancements will provide CalOptima Health with the ability to be robust and agile and to scale as a future-focused healthcare organization.

Discussion

By approving the purchase of additional Zscaler products for a ZTNA solution, CalOptima Health will enhance the capabilities of the existing product. This will provide secure web traffic and data loss prevention, reducing the risks associated with unauthorized access.

A ZTNA solution is a security tool that ensures strict access control to applications and data, regardless of the user's location or device. It enables organizations to secure their applications and data by granting access only to authorized users, enforcing strong authentication measures, and implementing granular access controls based on the principle of least privilege. ZTNA solutions also enable organizations to monitor and analyze user activity for compliance and forensic purposes. ZTNA facilitates the micro-segmentation of applications, preventing users from accessing applications and supporting networks beyond their designated interfaces for both on-premise and cloud applications. By implementing a ZTNA solution, CalOptima Health can effectively mitigate the risks of insider threats, external attacks, and data breaches while enhancing its overall security posture.

Furthermore, extending the contract with the existing Zscaler product and tools allows for seamless integration of our current internet Data Loss Prevention solution and secure web security tools with

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Zscaler, which are integral components of the ZTNA solution. Opting for another ZTNA solution would necessitate migrating these tools to the new platform, incurring additional integration costs.

Lastly, with the deployment of the ZTNA solution CalOptima Health will be able to eliminate the need for the legacy virtual private network client and its associated costs.

Fiscal Impact

The annual fiscal impact for the Zscaler Transformation is $475,000. It is a budgeted item in the proposed Fiscal Year 2023-24 Digital Transformation Strategy Operating Budget.

Rationale for Recommendation

By implementing a ZTNA solution, CalOptima Health can ensure that access to applications and data is strictly controlled and monitored, reducing the risk of insider threats and external cyber-attacks. Additionally, a ZTNA solution can help CalOptima Health enforce best practices for security and risk management.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Optiv, Inc.	1144 15th Street, Suite 2900	Denver	CO	80202
Zscaler, Inc.	120 Holger Way	San Jose	CA	95134

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

12. Authorize Amendment to the Standard Grant Agreement to Reflect Updated Insurance Requirements

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, (714) 954-2140

Recommended Action

Amend the standard grant agreement with updated insurance liability limits.

Background and Discussion

In September 2022, the CalOptima Health Board of Directors (Board) approved amendments to the Medi-Cal, OneCare, and OneCare Connect Ancillary Services contracts for Community Supports providers. These contract amendments updated the insurance liability limits required of Community Supports services providers. Liability categories affected included commercial general liability, commercial crime liability, and automobile liability.

This action was done in recognition that CalOptima Health's main partnership for Community Supports services is with local nonprofit community organizations. Staff have identified that the large majority of grant agreements are made with similar, and often the same, nonprofit organizations. Therefore, staff requests that the Board approve updated coverage levels for commercial general liability/automotive insurance in the standard grant agreement, similar to the levels adopted for the Community Supports provider contracts. The grant agreement does not call out commercial crime liability and workers' compensation, so that is not being added or amended.

The amendment will go into effect, pending Board approval, on the first day following the first month of Board approval. The grant agreement will otherwise remain in full force and effect, except as amended as described above.

Fiscal Impact

The recommended action is operational in nature and has no additional fiscal impact beyond what was included in the CalOptima Health Fiscal Year 2022-23 Operating Budget.

Rationale for Recommendation

Approval of the amendment will enable CalOptima Health to preserve and expand its partnership with community-based organizations.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Proposed Amendment: Grant Agreement

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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AMENDMENT No. 1 TO

GRANT AWARD AGREEMENT

This Amendment No. 1 to the Grant Award Agreement ("**Amendment**") is effective as of [insert date], 2023 ("**Amendment Effective Date**") by and between the Orange County Health Authority, a public agency dba CalOptima Health ("**CalOptima**"), and [Grantee Name] ("**Grantee**"). CalOptima and Grantee may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and Grantee entered into the Grant Award Agreement ("**Agreement**"), originally effective [insert date], under which CalOptima provided financial support to Grantee's Grant Project.

B. CalOptima and Grantee now desire to amend the Agreement to update insurance limit requirements.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Delete Section 5.1 of the Agreement in its entirety and replace it with the following new Section 5.1:

   5.1 **Grantee Comprehensive General Liability ("CGL")/Automobile Liability**. Grantee at its sole cost and expense shall maintain such policies of comprehensive general liability and automobile liability insurance and other insurance as shall be necessary to insure it and its business addresses, customers, employees, agents, and representatives against any claim or claims for damages arising by reason of (a) personal injuries or death occasioned in connection with the carrying out the project, (b) the use of any property of the Grantee, and (c) Grant Activities performed in connection with the Agreement, with minimum coverage of one million dollars ($1,000,000) per incident/two million dollars ($2,000,000) aggregate per year.

2. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

3. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern. Except otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

[*signature page follows*]

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR GRANTEE:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

13. Authorize Extending Contract with Infomedia Group, Inc., dba Carenet Healthcare Services for one year.

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Marie Jeannis, R.N., Executive Director, Population Health Management, (714) 246-8591

Recommended Actions

Authorize the Chief Executive Officer to revise payment terms and exercise the second one-year option to extend the contract term with Infomedia Group Inc., dba Carenet Healthcare Services (Carenet), from July 1, 2023, through June 30, 2024.

Background/Discussion

Effective July 1, 2019, CalOptima Health entered a three-year contract with Carenet. Carenet provides members with a 24/7 nurse advice line, supports after-hours calls for customer service and behavioral health, and provides member engagement services. The nurse advice line and after-hours support for customer service and behavioral health are regulatory requirements. In addition, Carenet provides member engagement and outreach support for COVID-19 vaccine appointment scheduling, CalFresh strategy, and quality measures and gaps in care initiatives.

In August 2022, the CalOptima Health Board ratified an amendment to the contract to include additional support services, revise the payment terms, and exercise the first one-year option to extend the contract term through June 30, 2023.

Currently, CalOptima Health has expanded Carenet's member engagement services to support Department of Health Services (DHCS) requirements for member outreach related to:

- Scheduling initial health appointments
- Completing the Health Information Form and Member Information Form (HIF/MET)

Carenet has requested increases to both clinician and non-clinician calls, an average increase of 7.5%, due to the increased cost of living and cost associated with recruitment and retainment of clinical staff.

Staff recommends exercising the second one-year renewal option to extend the contract agreement through June 30, 2024. Additionally, staff recommends amending the current agreement to increase rates by 7.8% for clinician calls and 7.1% for non-clinician calls. This extension supports compliance with regulatory requirements for the nurse advice line and after-hours calls and member outreach for completion of required assessments. Staff will evaluate the need to perform an RFP for these services prior to the end of the current contract term on June 30, 2024.

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Fiscal Impact
The recommended action to revise the payment terms and extend the contract with Carenet from July 1, 2023, through June 30, 2024, has an estimated additional annual fiscal impact of $54,000. Expenses associated with this increase have been included in the proposed CalOptima Health Fiscal Year 2023-24 Operating Budget.

Rationale for Recommendation
The recommended action will allow CalOptima to continue to meet regulatory requirements for nurse advice line services and after-hours call support, DHCS member outreach requirements, and to support timely member engagement activities.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Carenet Contract Amendment (Redacted)

Board Action(s)

Board Meeting Dates	Action	Term	Not to Exceed Amount
June 3, 2021	Consider Authorizing Amendment to Contract with Infomedia Group, Inc., dba Carenet Healthcare Services to Support Member Outreach Calls	July 1, 2019 – June 30, 2022	
August 4, 2022	Ratify Amendment to the Ancillary Services Contract with Infomedia Group Inc., dba Carenet Healthcare Services	June 30, 2022 – June 30, 2023	

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Infomedia Group Inc., dba Carenet Healthcare Services	11845 IH-10 West, Suite 400	San Antonio	TX	78230

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AMENDMENT III TO
ANCILLARY SERVICES CONTRACT

THIS AMENDMENT III TO THE ANCILLARY SERVICES CONTRACT ("Amendment III") shall be effective **July 1, 2023**, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and **Infomedia Group, Inc., dba Carenet Healthcare Services** ("Provider"), with respect to the following facts:

RECITALS

A. CalOptima and Provider have entered into an Ancillary Services Contract, by which Provider has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Provider desire to amend this Contract on the terms and conditions set forth herein.

NOW, THEREFORE, the parties agree as follows:

1. Section 7.1 "Term" shall be deleted in its entirety and replaced with the following:

   "7.1 Term. The term of this Contract shall become effective as of the Effective Date and continue for a three (3)-year period, ending on June 30, 2022 ("Initial Term"). Upon written notice to Provider prior to the completion of the Initial Term, CalOptima exercised the option to renew the Contract for an additional one-year extension, in which case the Contract remained in effect until June 30, 2023. CalOptima exercises the option to renew this Contract for additional one (1)-year term through June 30, 2024, upon approval by the CalOptima Board of Directors, unless earlier terminated by either Party as provided for in this Contract."

2. ATTACHMENT C – AMENDMENT II, COMPENSATION shall be deleted in its entirety and replaced with the new ATTACHMENT C – AMENDMENT III, COMPENSATION attached herein.

CONTRACT REMAINS IN FULL FORCE AND EFFECT- Except as specifically amended by this Amendment III, all other conditions contained in the Contract shall continue in full force and effect. After the effective date of this Amendment, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract.

IN WITNESS WHEREOF, CalOptima and Provider have executed this Amendment III.

FOR PROVIDER:	FOR CALOPTIMA:
Signature	Signature
Print Name	Yunkyung Kim Print Name
Title	Chief Operating Officer Title
Date	Date

ATTACHMENT C – AMENDMENT III

COMPENSATION

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima for all services rendered under the Contract, the lesser of Provider's billed charges or the following amounts:

I. Nurse Advice Line:

CalOptima shall reimburse for Covered Services as follows:

The monthly fee based on a per call model

Program Per Call Fee:	[redacted] per clinician call answered [redacted] per non-clinician call answered
Total call volume:	Pricing is based on a minimum 700 clinician calls answered per month, and 3,000 non-clinician calls answered per month
Language Services: Interpretation Services	[redacted] per minute

II. Member Engagement:

Live Outbound Calls: Live Outbound calls include complementary allotment of up to 2,000 calls per CalOptima's fiscal year (July – June). Any modifications to the outbound program set-up, to include script changes, reporting or file format, development, will be at the Professional Services Rate. Prior to work commencing, a time and cost effort will be provided to CalOptima for approval.

Additional CalOptima requests over the complementary 2,000 live outbound calls, CalOptima shall reimburse Provider for Covered Services as follows:

[redacted] per call

Provider shall not charge, and CalOptima will not reimburse Provider, for the first 2,000 live outbound calls to the identified CalOptima Members per CalOptima's fiscal year (July – June).

Provider shall not charge, and CalOptima will not reimburse Provider, for invalid dialer detected numbers (disconnected, bad number or fax)

Any invalid numbers shall not count as part of the 2,000 calls per fiscal year, for which there is no separate charge, and for which CalOptima will not reimburse Provider.

Provider shall attempt to reach each Member a maximum of three (3) times. Average call length will not exceed three (3) minutes.

Program Support – Any standard maintenance and support services requested by CalOptima related to Member Engagement is included in this pricing unless additional campaigns are requested as identified in any modifications to the outbound program set-up, to include script changes, reporting or file format, development, will be at the Professional Services Rate. Prior to work commencing, a time and cost effort will be provided to CalOptima for approval.

Member Engagement Strategies – Interactive Voice Recording described below.

Member Engagement Strategies – Interactive Voice Recording (IVR). IVR/Automated messaging technologies include complementary allotment of up to 375,000 IVR calls per CalOptima's fiscal year (July – June). Provider will provide individual quote for CalOptima IVR campaign requests over the 375,000 allotments. These 375,000 IVR calls shall be limited to two (2) unique scripts per year. Additional unique scripts will be billed in accordance with the Professional Services Rates in Section III of this Attachment C.

III. Professional Services Rates

Professional Services	Hourly Rate
Application Development/Programming/IT Professional Services and launching/delivery of a new campaign or modification to an existing campaign.	[redacted]
Marketing and Creative Services	[redacted]
Client Relationship Manager	[redacted]
Program Support – Any maintenance and support services requested by CalOptima that are outside Provider's standard service described in this SOW	[redacted]
Curriculum and Training Materials Development	[redacted]
Training Delivery (Hours required by the trainer to train each class)	[redacted]
Clinical Employee Program Training	[redacted]
Non-Clinical Employee Program Training	[redacted]
Any audit, compliance, including delegation oversight audit requests, quality inspections, or any general inspections requests (> 5 hours per/annual contract)	[redacted]
CalOptima-Requested Travel	At Cost, as Prior Approved by CalOptima

IV. Payment Procedures:

Provider shall bill CalOptima with the assigned purchased order, and the invoice shall include a Unique Member Engagement Outreach Monthly Totals.

CalOptima agrees to make a payment to Provider of undisputed amounts within thirty (30) business days from receipt of an invoice services provided by Provider under this Contract.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

14. Approve Actions Related to State Advocacy Services

Contact

Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Action

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to extend CalOptima Health's contract with Edelstein Gilbert Robson & Smith LLC (EGRS) for state advocacy services through September 30, 2023; and
2. Approve the proposed Scope of Work (SOW) for state advocacy services, effective October 1, 2023, and authorize the release of the associated Request for Proposals (RFP).

Background

CalOptima Health retains representation in Sacramento to assist with tracking and advocacy on legislation, analyzing and developing positions on bills, and analyzing recommended actions pertaining to state budget and regulatory issues. In addition, CalOptima Health representatives develop and maintain relationships with members of the California State Legislature, legislative committee staff and consultants, and applicable state departments and regulatory agencies.

As part of CalOptima Health's standard procurement process, an RFP for state advocacy services was issued in March 2018, and proposals were received from two advocacy firms. Subsequently, evaluation and interviews were conducted by CalOptima Health staff, external subject matter experts, and a Board of Directors (Board) ad hoc committee, which recommended EGRS. On June 7, 2018, the Board authorized the CEO to contract with EGRS for a one-year term, commencing on July 1, 2018, with four one-year extension options, each exercisable at CalOptima Health's sole discretion. On May 5, 2022, the Board exercised the fourth and final one-year option to extend the current contract term through June 30, 2023.

Discussion

Since the Board has exercised all options to extend CalOptima Health's current contract with EGRS, staff is preparing to release a new RFP for state advocacy services. As a result of the necessary timeline required to complete the standard RFP process, a new contract for state advocacy services cannot be executed before the expiration of the current contract on June 30, 2023. In order to ensure that CalOptima Health has consistent, uninterrupted representation in Sacramento for the remainder of the current legislative session, which is expected to adjourn on September 14, 2023, the recommended action is to authorize the extension of the current contract with EGRS, under the existing terms and conditions, for three additional months through September 30, 2023. The EGRS contract fee is $8,333.33 per month, which includes phone, fax, in-office copying, regular postage and printing, as well as a separate pass-through fee of $150 per quarter for an EGRS subcontractor to file lobbying disclosures with the California Secretary of State. Any out

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of the ordinary expenses, such as airline travel, will be incurred only if authorized in advance by CalOptima Health.

In addition, staff requests the Board's approval of an updated SOW to be included as part of the forthcoming RFP and contract for state advocacy services, effective October 1, 2023, upon the expiration of the recommended contract extension with EGRS. This recommended action also includes authorization for the release of the associated RFP. Upon the completion of the RFP process, staff will return to the Board with a request to select a firm and authorize a contract for state advocacy services, effective October 1, 2023.

Fiscal Impact

Funding for the recommended action to extend the contract with EGRS under the same terms and conditions for state legislative advocacy services from July 1, 2023, through September 30, 2023, is included under the proposed CalOptima Health Fiscal Year 2023-24 Operating Budget.

Rationale for Recommendation

State advocacy efforts continue to be a priority for CalOptima Health given the level of activity on health care issues in Sacramento. CalOptima Health anticipates that several important issues will require focus, attention, involvement and advocacy.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Entities Covered by this Recommended Board Action
2. EGRS Contract No. 18-10701 (As Currently Amended)
3. Proposed SOW for State Advocacy Services

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Edelstein Gilbert Robson & Smith LLC	1127 11th Street, Suite 1030	Sacramento	CA	95814

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CONTRACT NO. 18-10701

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, dba CALOPTIMA and

EDELSTEIN, GILBERT, ROBSON & SMITH, L.L.C.

THIS CONTRACT ("Contract") is made and entered into as of the date last signed below, by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima" and Edelstein, Gilbert, Robson & Smith, L.L.C. a Limited Liability Company (LLC), hereinafter referred to as "CONTRACTOR." CalOptima and CONTRACTOR shall be referred to herein collectively as the "Parties" or individually as a "Party."

RECITALS

A. CalOptima desires to retain a CONTRACTOR to provide State Legislative Advocacy Services for CalOptima, as described in the Scope of Work; and

B. CONTRACTOR provides such services; and

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

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. This Contract shall include the following documents ("Contract Documents"), in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and attachments, and any amendments thereto; (ii) CalOptima's Request for Proposal ("RFP") 18-039, if applicable, inclusive of any revisions, amendments and addenda thereto, and (iii) CONTRACTOR's proposal dated April 13, 2018. 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 documents attached to this Contract and/or referenced herein as a "Contract Document" are incorporated into this Contract by this reference, with the same force and effect as if set forth herein in their entirety. 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 Section 17, Modifications, herein. In the event of any conflict of provisions among the documents constituting the Contract, the provisions shall prevail in the above-referenced descending order of precedence.

2. Statement of Work.

2.1 CONTRACTOR shall perform the work necessary to complete, in a manner satisfactory to CalOptima, and if applicable, to the Centers for Medicare and Medicaid Services ("CMS"), the California Department of Health Care Services ("DHCS"), and/or the California Department of Managed Health Care ("DMHC"), as applicable, the services set forth in Exhibit A entitled "Scope of Work," which is attached hereto and incorporated herein by this reference. CONTRACTOR shall also perform in accordance with its Proposal dated April 13, 2018.

2.2 CONTRACTOR shall provide the personnel listed below to perform the above-specified services, which persons are hereby designated as key personnel under this Contract. No person named in this Section 2, or his/her successor approved by CalOptima, shall be removed or replaced by CONTRACTOR, nor shall his/her agreed-upon function or level of commitment hereunder be changed without the prior written consent of CalOptima.

Name	Function/Title
Don Gilbert	Partner
Trent Smith	Partner

3. Insurance.

3.1 Prior to undertaking performance of services under this Contract and at all times during performance hereunder, and entirely at CONTRACTOR's sole expense, CONTRACTOR shall maintain the following insurance, which shall be full-coverage insurance not subject to self-insurance provisions, and CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the term of this Contract:

3.1.1 Required Insurance:

3.1.1.1 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:

3.1.1.2 Per Occurrence: $1,000,000

3.1.1.3 Personal Advertising Injury: $1,000,000

3.1.1.4 Products Completed Operations: $2,000,000

3.1.1.5 General Aggregate: $2,000,000

3.1.2 Commercial Automobile Liability covering any auto, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,200,000 combined single limit for bodily injury or property damage.

3.1.3 Workers' Compensation and Employers' Liability Policy written in accordance with the laws of the State of California and providing coverage for all of CONTRACTOR's employees:

3.1.3.1 This policy must provide statutory coverage for Workers' Compensation.

3.1.3.2 This policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

3.1.4 Professional Liability insurance covering the CONTRACTOR's professional errors and omissions with the following minimum limits of insurance:

3.1.4.1 Per occurrence: $1,000,000

3.1.4.2 General aggregate: $2,000,000

3.1.5 Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and theft of client property, with the following minimum limits of $1,000,000 per occurrence:

3.1.5.1 Cyber and Privacy Liability insurance with the following minimum limits of insurance covering claims involving privacy violations, 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 is required only if any products and/or services related to information technology (including hardware and/or software) are provided to Insured and for claims involving any professional services for which CONTRACTOR is engaged with Insured for such length of time as necessary to cover any and all claims.

a) Privacy and Network Liability: $1,000,000

b) Internet Media Liability: $1,000,000

c) Business Interruption & Expense: $1,000,000

d) Data Extortion: $1,000,000

e) Regulatory Proceeding: $1,000,000

f) Data Breach Notification & Credit Monitoring: $1,000,000

3.2 Prior to commencement of any work hereunder, CONTRACTOR shall furnish to CalOptima's Purchasing Department additional insured endorsements and also broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR, and further providing that:

Certificate Requirements:

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 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 as respects 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.

3.2.3 The Insurance Company 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 clause. All certificates and endorsements are to be received and approved by CalOptima before work commences. 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 above, 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 Thirty (30) days prior written notice of cancellation be given to CalOptima.

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3, CalOptima shall have the right, at its election, to terminate forthwith this Contract. 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 herein.

3.6 "Occurrence," as used herein, 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 agrees to and shall save, defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "Indemnified Parties") from and against any liability whatsoever, based or asserted upon any services of the CONTRACTOR, its officers, employees, subcontractors, agents, or representatives (individually and collectively referred to as "Indemnitors") arising out of or in any way relating to this Contract, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever arising from the performance of Indemnitors under this Contract. CONTRACTOR shall defend the 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, but not limited to, attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding.

4.2 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR 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. The terms of this Contract are contractual and the result of negotiation between the Parties hereto. Accordingly, any rule of construction of contracts (including, without limitation, 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.

4.3 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.

4.4 It is expressly understood and agreed that the foregoing provisions are intended to be as broad and inclusive as permitted by the law of the State of California and that CONTRACTOR's indemnification and duty to defend obligation hereunder shall survive the expiration or earlier termination of this Contract until such time as action against the Indemnified Parties for such matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including but not limited to those set forth under the California Government Claims Act (Cal. Gov. Code §900 et seq.).

4.5 The terms of this Section shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which term shall include any and all subcontractors, and any agents or 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. 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 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. At CONTRACTOR's expense as described herein, 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, without limitation, attorneys' fees as provided herein arising out of CONTRACTOR's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "Employment Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

6. Assignments; Subcontracts.

6.1 Except as specifically permitted hereunder, CONTRACTOR may not assign, transfer, delegate or subcontract any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion. In the event CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, delegation, or subcontract may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, delegation, or subcontract made without CalOptima's express written consent shall be deemed void.

6.2 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 CONTRACTOR (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 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.

6.3 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Non-Exclusive Relationship. It is understood by the parties that 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.

8. 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 Policies relating to services under the Contract that are in effect when this Contract is signed or which may come into effect during the term of this Contract.

9. Nondiscrimination Clause Compliance.

9.1 During the performance of this Contract, CONTRACTOR 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. CONTRACTOR and subcontractor(s) shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. CONTRACTOR 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. CONTRACTOR 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. CONTRACTOR shall also fully comply with the following, to the extent applicable to the services provided by CONTRACTOR under this Contract: Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as California Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); California Civil Code Section 51 (all types of arbitrary discrimination); and all rules and regulations promulgated pursuant thereto.

9.2 CONTRACTOR shall include the nondiscrimination and compliance provisions of Section 9 in all subcontracts under this Contract.

10. Prohibited Interest.

10.1 CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict of interest laws, including but not limited to CalOptima's Conflict of Interest Code, the California Political Reform Act (Government Code Section 81000 et seq.) and Government Code Section 1090 et seq. (collectively, the "Conflict of Interest Laws").

10.2 CONTRACTOR covenants that, for the term of the Contract, no director, officer, or employee of CalOptima during his tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the term of this Contract, and consistent with the provisions of Title 22 California Code of Regulations (CCR) Section 53600(f), no state officer or state employee shall be employed in a management or contractor position by CONTRACTOR within one year after the state office or state employee has terminated state employment.

10.3 No employee, officer or agent of CalOptima shall participate in the selection, award or administration of an agreement, or in any decision that may have foreseeable impact on CONTRACTOR if a conflict of interest, real or implied, exists. Such a conflict arises when any of the following has a financial or other interest in the firm selected for award:

10.3.1 A CalOptima employee, officer or agent;

10.3.2 Any member of the employee, officer or agent's immediate family;

10.3.3 The employee, officer or agent's domestic or business partner; and

10.3.4 An organization that employs or is about to employ any of the above.

10.4 CONTRACTOR understands that, if this Contract is made in violation of Government Code Section 1090 et seq., the entire Contract is voidable and 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, in addition to the foregoing, CONTRACTOR may be subject to criminal prosecution for a violation of Government Code Section 1090.

10.5 If CONTRACTOR hereinafter becomes aware of any facts, which might reasonably be expected to either create a conflict of interest under the Conflict of Interest laws or violate the provisions of this Section, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include, without limitation, identification of all persons, entities and businesses implicated and a complete description of all relevant circumstances.

11. Disclosure of Officers, Owners, Stockholders and Creditors. 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 I, attached hereto and incorporated by this reference:

11.1 All officers and owners who own greater than 5% of the CONTRACTOR; and

11.2 All stockholders owning greater than 5% of any stock issued by CONTRACTOR.

11.3 All creditors of CONTRACTOR's business if such interest is over 5%.

12. Equal Opportunity.

12.1 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, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. CONTRACTOR and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or Department of Health Care Services ("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 under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

12.2 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.

12.3 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, advising the labor union or workers' representative of CONTRACTOR and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

12.4 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 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.

12.5 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 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

12.6 In the event of CONTRACTOR and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and 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 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

12.7 CONTRACTOR 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, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or CONTRACTOR. 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 in the event CONTRACTOR and its Subcontractors become involved in, or are threatened with litigation by a subcontractor or CONTRACTOR as a result of such direction by DHCS, CONTRACTOR and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

13. Standard of Performance; Warranties.

13.1 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.

13.2 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, 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.

13.3 CONTRACTOR expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including, without limitation, 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 to other parts of the system resulting from such defects. CalOptima shall give notice to CONTRACTOR of any observed defects. In the event that CONTRACTOR fails to make adjustments, repairs, corrections, or other work made necessary by such defects, CalOptima may do so and charge CONTRACTOR the costs incurred.

13.4 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.

13.5 CONTRACTOR's obligations under this Section 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.

13.6 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair and replacement by CONTRACTOR at no cost to CalOptima.

14. Compensation.

14.1 Payment.

14.1.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full consideration for the faithful performance of this Contract, the rates, charges and other payment terms identified in Exhibit B, which is attached hereto and incorporated herein by this reference.

14.1.2 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.

14.1.3 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 as set forth in the Contract and Exhibit A, Scope of Work that may be reasonably expected by CalOptima. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING UNDER THIS CONTRACT.**

14.1.4 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 the attached Exhibit B, without the express prior written authorization of CalOptima. CONTRACTOR shall at all times monitor its costs and expenditures for work performed under this Contract, and shall monitor its invoices, costs, and expenditures, to ensure it does not exceed the maximum cumulative payment obligation set forth herein. CONTRACTOR shall provide CalOptima with 60 days written notice if at any time during this Contract CONTRACTOR becomes aware that it may exceed the maximum cumulative payment obligation authorized under this Contract. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

14.1.5 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.

14.2 Contractor Travel Policy. CONTRACTOR agrees to abide by the terms of the CalOptima Travel Policy, attached hereto as Exhibit C, and incorporated herein by this reference.

15. Term. This Contract shall commence no later than 07/01/2018 and shall continue in full force and effect through 06/30/2019, ("Initial Term"), unless earlier terminated as provided in this Contract. At the end of the Initial Term, CalOptima may, at its option, extend this Contract for up to four (4) additional consecutive one (1) year terms ("Extended Terms"), provided that if CalOptima does not exercise its option to extend at the end of the Initial Term, or any Extended Term, the remaining option(s) shall automatically lapse. As used in this Contract, the word "Term" shall include the Initial Term and any and all Extended Term(s), to the extent CalOptima exercises its option pursuant to this paragraph.

16. Termination.

16.1 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 thirty (30) days written notice hereof. Upon termination, CalOptima may pay CONTRACTOR its allowable cost incurred for services satisfactorily performed and accepted by CalOptima as of the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

16.2 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:

16.2.1 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.

16.2.2 In the event of Termination for Unavailability of Funds, as provided in this Section, 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, without limitation, lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

16.2.3 In the event of Termination for Unavailability of Funds, as provided in this Section, 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 CONTRACTOR 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.

16.3 Termination for Default. Subject to a ten (10) day cure period, CalOptima may terminate this Contract for CONTRACTOR's default, or if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR, or if CONTRACTOR makes an assignment for the benefit of creditors as defined in Section 6, or if CONTRACTOR 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 Section, CONTRACTOR 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 CONTRACTOR under this Contract.

16.4 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3, (Insurance), Section 10, (Prohibited Interest), or Section 24, (Confidentiality).

16.5 Effect of Termination. Upon expiration or receipt of a termination notice under this Section:

16.5.1 CONTRACTOR shall promptly discontinue all services (unless the 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 but not limited to 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. Failure to return any information or equipment, badge or access card, is considered a material breach of this Contract and CalOptima's privacy and security rules.

16.5.2 CalOptima may take over the services,and may award another party a contract to complete the services under this Contract.

16.5.3 CalOptima may withhold from payment any sum that it determines to be owed to CalOptima by CONTRACTOR, or as necessary to protect CalOptima against loss due to outstanding liens or claims of former lien holders.

17. 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 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 its performance.

18. 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 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 Care 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 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. This provision shall also apply to any agreement between a subcontractor and an organization related to the 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 related to Medicare enrollees, 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 CONTRACTOR's subcontractors.

19. Confidential Material.

19.1 During the term of this Contract, 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" shall include without limitation the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements and licensing plans 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. 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.

19.2 For the purposes of this Section 19, "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's Confidential Information or proprietary information; (iv) is received from a third party which 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.

19.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers or agents on a "need to know" basis in connection with the services performed under this Contract, who are bound by confidentiality obligations no less stringent than these prior to any disclosure. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; providing that the receiving Party shall give reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and shall assist 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 any other party.

19.4 Except as to the confidentiality of trade secrets, these confidentiality restrictions and obligations will terminate five (5) years after the expiration or termination of the Contract, unless the law requires a longer period. Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party all documents, notes and other tangible materials representing the disclosing Party's Confidential Information or Proprietary 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.

19.5 For the purposes of this Section only, "Confidential Information" does not include protected health information 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 Protected Health Information is referenced below in Section 24, and shall be governed by a Business Associate Protected Health Information Disclosure Agreement, which shall be executed by the parties if CONTRACTOR will create, receive, maintain, use, or transmit Protected Health Information in performing services under this Contract.

20. Record Ownership and Retention.

20.1 The originals of all letters, documents, reports, software programs 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.

20.2 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, but not limited to, 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.

20.3 Notwithstanding the foregoing, CONTRACTOR's intellectual property ("CONTRACTOR IP") that preexists this Contract shall remain the sole and exclusive property of CONTRACTOR. CONTRACTOR shall not incorporate any CONTRACTOR IP into the Works that would limit CalOptima's use of the Works without CalOptima's written approval. To the extent that CONTRACTOR incorporates any CONTRACTOR IP into the Works, CONTRACTOR hereby grants to CalOptima a non-exclusive, irrevocable, perpetual, worldwide, royalty-free license to use and reproduce the CONTRACTOR IP to the extent required to fully utilize the Works.

20.4 CONTRACTOR acknowledges and agrees that, notwithstanding any provision herein to the contrary, CalOptima's Intellectual Property ("CalOptima IP") in the information, documents and other materials provided to CONTRACTOR shall remain the sole and exclusive property of CalOptima. Any information, documents or materials provided by CalOptima to CONTRACTOR pursuant to this Contract and all copies thereof (including without limitation CalOptima IP, Proprietary Information and Confidential Information, as these terms are defined in Section 19) shall upon the earlier of CalOptima's request or the expiration or termination of this Contract be returned to CalOptima.

20.5 For purposes of this Section, Intellectual Property shall mean patents, copyrights, trademarks, trade secrets, and other proprietary information.

21. Patent and Copyright Infringement. In lieu of any other warranty by CalOptima or CONTRACTOR against infringement, statutory or otherwise, it is agreed that CONTRACTOR shall indemnify, hold harmless and 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, trademark, copyright, or other intellectual property right, and shall pay costs and damages finally awarded in any such suit, provided that CONTRACTOR is notified in writing of the suit and given authority, information, and assistance at CONTRACTOR's expense for the defense of the suit. CONTRACTOR, 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.

22. 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.

23. Business Associate Protected Health Information Disclosure Agreement. This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit Protected Health Information. As such, no Business Associate Agreement is required for this Contract.

24. Confidentiality of Member Information.

24.1 CONTRACTOR and its employees, agents, or subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving

services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to 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 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 not emanating from the Member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

24.2 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by 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 Member under this Contract that is obtained by CONTRACTOR or its Subcontractors, CONTRACTOR:

24.2.1 Will not use any such information for any purpose other than carrying out the express terms of this Contract;

24.2.2 Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law;

24.2.3 Will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under; and

24.2.4 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.

24.3 CONTRACTOR agrees to complete a CalOptima Medi-Cal Data Access Agreement, which is attached hereto as Exhibit D and incorporated herein by this reference. All materials covered under this Medi-Cal Data Access Agreement shall be designated confidential, to the extent permitted by California law.

25. Medicare Advantage Program. CONTRACTOR agrees to abide by the terms of "Addendum 1, Medicare Advantage Program," attached hereto as Exhibit G and incorporated herein by this reference.

26. Time is of the Essence. Time is of the essence in performance of this Contract.

27. 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.

28. 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.

29. Choice of Law. This Contract shall be governed by and construed in accordance with all 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 the County of Orange, California.

30. 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.

31. Notices. All notices required or permitted under this Contract and all communications regarding the interpretation of the terms of this Contract, or changes thereto, 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 party whose address changes shall notify the other party in writing.

To CONTRACTOR:	To CalOptima:
Edelstein, Gilbert, Robson & Smith, LLC	CalOptima
1127 11th Street, Suite 1030	505 City Parkway West
Sacramento, CA 95814	Orange, CA 92868
Attention: Trent Smith	Attention: Mark Finch, C.P.M., CPPO, CPSM
Partner	Purchasing Manager

32. 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. CONTRACTOR shall insert the substance of this entire clause in any subcontract hereunder as to which a labor dispute may delay this Contract.

33. Unavoidable Delays.

33.1 If the delivery of services under this Contract should be unavoidably delayed, CalOptima's Purchasing Department shall extend the time for completion of the Contract 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 CONTRACTOR's performance, and was not caused directly or substantially by acts, omissions, negligence, or mistakes of CONTRACTOR, CONTRACTOR's subcontractors, or their agents, and was substantial and in fact caused CONTRACTOR to miss delivery dates, and could not adequately have been guarded against by contractual or legal means. Delays caused by CalOptima will be sufficient justification for delay of services, and CONTRACTOR shall be allowed a day-for-day extension.

33.2 CONTRACTOR shall notify CalOptima's Purchasing Department as soon as CONTRACTOR has, or should have, knowledge that an event has occurred that will delay deliveries. Within five (5) working days, CONTRACTOR shall confirm such notice in writing, furnishing as much detail as is available.

33.3 CONTRACTOR agrees to supply, as soon as such data is available, any reasonable proof that is required by CalOptima's Purchasing Department to make a decision on any request for extension. CalOptima's Purchasing Department shall examine the request and any documents supplied by CONTRACTOR and shall determine if CONTRACTOR is entitled to an extension and the duration of such extension. CalOptima's Purchasing Department shall notify CONTRACTOR of this decision in writing. It is expressly understood and agreed that CONTRACTOR 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.

34. No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, 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.

35. Attorneys' Fees. Should either party to this Contract institute any action or proceeding to enforce or interpret 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.

36. Entire Agreement. This Contract, including all exhibits and documents incorporated by reference and all Contract Documents referenced in Section 1 herein, 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.

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

38. Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power, or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof, or of any other covenant, condition, or agreement herein contained. 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.

39. 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 "Public Records Act"). CONTRACTOR 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. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the Public Records Act. In the event that 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 Public Records Act that are not so marked. In the event CalOptima receives a request under the Public Records Act 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. 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, without limitation, attorneys' fees, and any costs awarded to the person or entity that sought the CONTRACTOR 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 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.

40. Audit Disclosure. Pursuant to California Government Code Section 8546.7, if this Contract is over ten thousand dollars ($10,000), it is subject to examination and audit of the 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 or its attachments, CONTRACTOR agrees that, during the term of this Contract 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.

41. Debarment and Suspension Certification.

41.1 By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable Federal suspension and debarment regulations.

41.2 By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

41.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

41.2.2 Have not within a three-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 antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

41.2.3 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 Paragraph 41.2.2 herein;

41.2.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

41.2.5 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 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

41.2.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

41.3 If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima.

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

41.5 If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

42. Lobbying Restrictions and Disclosure Certification.

42.1 Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.

42.2 Certification and Disclosure Requirements.

42.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Exhibit E, Part 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 42.3of this provision. Exhibit E is attached hereto and incorporated herein by this reference.

42.2.2 Each recipient shall file a disclosure (in the form set forth in Exhibit E, Part 2, entitled "Certification Regarding Lobbying") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 42.3 of this provision if paid for with appropriated funds.

42.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 42.2.2herein. An event that materially affects the accuracy of the information reported includes:

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

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

42.2.3.3 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.

42.2.3.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 42.2.1of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

42.2.3.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 42.2.1of this provision. That person shall forward all disclosure forms to CalOptima Purchasing Manager.

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

43. Air and Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR § 15.5. 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.

44. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Prohibited Interest, Warranties, Compensation, Confidentiality, Indemnification, Duty to Defend, Ownership of Records and Documents, Record Retention, Audit Disclosure, California Public Records Act, Patent and Copyright Infringement, Governing Law, and this Section.

45. Severability. If any section, subsection or provision of this Contract, or any Contract Documents incorporated into 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 not be affected thereby.

46. 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.

47. 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 to this Contract. Nothing in this Contract is intended to confer upon any Party other than the Parties hereto 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.

48. 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.

49. 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.

[Remainder of page left intentionally blank. Signatures on following page]

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. 18-10701 on the day and year last shown below.

[VENDOR NAME] Edelstein Gilbert Robinson-Smith, LLC	CalOptima
By:	By:
Print Name: Treat E. Smith	Print Name: Greg Hamblin
Title: Manager	Title: CFO & Treasurer
Date: August 16, 2018	Date: 9-4-18

By:
Print Name: Donald B. Gilbert
Title: Manager
Date: August 16, 2018

If CONTRACTOR is a corporation, two officer signatures or a Corporation Resolution or Corporate Seal is required

Exhibit A

A. SCOPE OF WORK

CONSULTANT shall represent CalOptima's day-to-day interests in Sacramento with the California State Legislature, the Administration, and other relevant departments and agencies, offering legislative monitoring and other necessary advocacy services to CalOptima.

B. REPORTING RELATIONSHIP

The Chief Executive Officer; Executive Director, Public Policy and Public Affairs; and Director, Government Affairs (Business Owners) and/or their designee(s) will be the primary contacts and will direct the work of the CONSULTANT. All work in excess of that expressed in this Scope of Work shall be approved by the Business Owners in conjunction with the Purchasing department. This additional work will be evidenced in an amendment to this Contract prior to the work commencing.

C. OBJECTIVES/DELIVERABLES

CONSULTANT shall:

1. Maintain regular contact with members of the California Legislature, committee staff, and other state departments, agencies, boards and commissions, to identify impending changes in laws, regulations and funding priorities that relate to CalOptima.

2. Provide a written monthly report that shall accompany the invoice to describe the nature and extent of the services or actions taken on behalf of CalOptima as well as report on issues in Sacramento that may impact CalOptima's programs and funding. Written reports should also include general information regarding the health care industry in California that may have a direct or indirect impact on CalOptima.

3. Notify CalOptima of anticipated, introduced or amended state legislation, and regulations that could impact CalOptima. These activities include but are not limited to:

   Providing bill numbers and a brief summary of introduced or amended state legislation;

   Providing copies of legislation and committee analysis; and

   Providing information related to legislative hearings.

4. Advocate for CalOptima's programs and positions on proposed legislation, proposed regulations, and funding priorities as directed. These activities shall include by are not limited to:

Informing CalOptima of upcoming legislative proposals, budget forecasts and relevant policy issues;

Assisting in securing authors and drafting language for sponsored bills;

Assisting in drafting amendments to legislation;

Testifying on behalf of CalOptima at legislative hearings; and

Monitoring, reviewing and providing ongoing advice regarding the impact of the State budget on CalOptima's programs
Drafting letters of support/opposition

5. Provide copies of all written correspondence, testimony and position papers given on behalf of CalOptima, as well as provide copies of the State Budget and any related documents to the Business Owners.

Exhibit B

PAYMENT

A. 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 and subject to the maximum cumulative payment obligations specified below.

B. CONTRACTOR shall invoice CalOptima on a monthly basis. The 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.

C. 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. 18-10701 provide a 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.

D. 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 One Hundred Thousand Dollars ($100,000), for the initial contract term 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.

E. CONTRACTOR's billable rate shall be Eight Thousand Three Hundred Thirty-Three Dollars and Thirty-Three Cents $8,333.33 per month. This rate is fixed for the duration of the Contract. CONTRACTOR agrees to extend this rate to CalOptima for a period of one year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

F. CONTRACTOR shall also invoice CalOptima on aa as-needed basis for travel-related expenses to CalOptima. All expenses charged to CalOptima under this Contract shall be consistent with Exhibit C, CalOptima's Travel Policy. Receipts or reasonable evidence thereof are required for commercial travel, car rental, parking, lodging, and food. When CONTRACTOR personnel visit more than one client on the same trip, the expenses incurred shall be apportioned in relation to time spent with each client.

Exhibit C

CalOptima Travel Policy

CalOptima
A Public Agency
Better. Together.

Policy #:	GA.5004		
Title:	**Travel Policy**		
Department:	Finance		
Section:	Purchasing		
CEO Approval:		Michael Schrader	MS
Effective Date:	8/1/12	Revised: 9/6/12, 3/1/13	
Board Approval:	9/6/12		

I. PURPOSE

To establish a process for reasonable and equitable reimbursement of approved travel and other related expenses incurred by CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants while traveling on authorized CalOptima Business.

II. POLICY

A. For the purpose of this policy, Individual shall mean, unless otherwise specified, all persons authorized to submit an Expense Report, including: CalOptima Board members, CalOptima Standing Committee members, CalOptima employees, and; individuals under contract to CalOptima for which the approved contract provides for reimbursement of travel and/or conference expenses, in accordance with CalOptima rules and regulations.

B. CalOptima shall provide an expense reimbursement process to ensure timely and accurate identification, approval, processing, recording, payment, and monitoring of all necessary travel expenses and miscellaneous expenses incurred by authorized Individuals, in accordance with generally accepted accounting principles (GAAP), and in compliance with State and Federal regulations.

C. CalOptima shall reimburse employees for reasonable expenses incurred while traveling on CalOptima business. All travel must be for the benefit of CalOptima, and must be completed at the most reasonable cost based on the facts and circumstances surrounding the travel. This includes making reservations for air travel and other expenses as soon as possible to access better rates. Employees are expected to use good judgment when traveling, seeking to minimize travel costs whenever possible.

1. Travel Expenses shall include the following items:

   a. Transportation: including commercial carriers, rental vehicles, and mileage for use of personal vehicle;

   b. Lodging;

   c. Meals;

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

   e. Insurance for rental vehicles;

   f. Parking fees and tolls fees (i.e., toll roads and necessary parking);

g. Miscellaneous expenses including:

i. Authorized local and long-distance telephone calls;

ii. Baggage fees;

iii. Internet or Wi-Fi charges;

iv. Facsimiles;

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

vi. Taxi or public transit fares, required to conduct business; and

vii. Other unforeseen or unusual expenses that are properly justified and substantiated.

D. Board Member/Standing Committee Member Travel

1. CalOptima shall allow Board members and Standing Committee members reasonable and necessary Travel Expenses and miscellaneous expenses incurred when participating in activities as a member of their respective Board or Committee. Eligible Travel Expenses shall be governed by this policy.

a. The CEO or the Chairperson of the CalOptima Board of Directors, or his or her designee, shall review and approve all Board member and Standing Committee member non-local travel.

b. CalOptima shall limit Board member and Standing Committee member travel to the following purposes:

i. CalOptima business-related activities;

ii. Requests to represent CalOptima as a speaker at an approved meeting, seminar or conference; and

iii. Other travel deemed necessary by the CalOptima Board of Directors.

E. Travel Approval

1. Budgeted Travel: All budgeted Travel and miscellaneous expenses for CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants shall be pre-approved by the appropriate level of CalOptima Management or Board Chair, prior to travel expenses being incurred, according to the following:

Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee
CEO	Board Chairperson or designee
Board Member/Standing Committee Member	Board Chairperson, CEO or designee

2. Non-Budgeted Travel: Non-Budgeted Travel and miscellaneous expenses for authorized Individuals shall be pre-approved by the CEO, or his or her designee, prior to Travel Expenses being incurred.

F. Conferences and Seminars

1. Attendance at any given conference and/or seminar shall be:

   a. Limited to the number of Individuals deemed appropriate by the CEO for that particular conference or seminar, and

   b. Approved by Human Resources.

2. Payment of Fees

   a. Conference and/or seminar fees shall be prepaid whenever possible, to take advantage of early registration discounts. An employee shall request prepayment of conference and seminar fees at the time the Travel and Training Authorization form is prepared, and submit necessary registration information to the Purchasing Department.

   b. In the event an Individual must personally pay for conference or seminar registration fees, the Individual shall request reimbursement on an Expense Report with a pre-approved Travel and Training Authorization Form.

G. Meal Expenses

1. Travel Meals are those food items consumed when traveling on CalOptima Business away from the primary workplace.

2. CalOptima shall reimburse authorized Individuals the actual cost of Travel Meals, excluding alcoholic beverages, in an amount not to exceed forty-five dollars ($45.00) per day, excluding taxes and gratuity.

   a. CalOptima shall reimburse employees and Board members for meals that exceed the forty-five dollars ($45.00) per day under the following conditions:

      i. The authorized Individual shall submit a valid receipt for such meals with a brief explanation of the expenditure. Individual meals shall be subject to the above limitations;

ii. The authorized Individual elects to pay for the meals of individuals with whom authorized CalOptima Business was conducted; or

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

iv. Expense reports containing extraordinary meal expenditures shall require approval of the CEO, or his or her designee.

b. CalOptima may negotiate individual meal per diem amounts for individual contractors authorized to receive reimbursement for expenses, as stipulated in this policy. Individual contractor per diem rates may be less than, but shall not exceed, the established employee, Board and Committee member meal reimbursement rate.

3. CalOptima shall reimburse for Business Meals at actual reasonable and necessary expenses for refreshments or meals, excluding alcoholic beverages, provided in conjunction with on-site or off-site meetings (e.g., in-house developed formal training sessions, conferences, seminars, workshops, staff meetings, and board and commission meetings) which extend over normal breaks or meal periods. An Expense Report for Business Meals must include receipt, names of those in attendance, and the business topic.

H. Lodging Expenses

1. CalOptima shall reimburse the cost of a single room at an Approved Lodging Facility for Non-Local Travel.

2. Adequate lodging expenses will be allowed. Price is an issue in selecting "adequate lodging". Prudence and good stewardship should be used when selecting a lodging facility. Comparison shopping is encouraged; booking through online travel Websites, as opposed to directly with the lodging facility, might provide opportunities for reduced cost lodging. Itemized receipts for lodging must be provided to obtain reimbursement.

3. Travelers should seek lodging rates (excluding taxes and fees) at or below the federal government's per diem rate. If such rates are not available, a hotel's discounted government rate shall be allowed. A schedule of federal lodging per diem rates is available on the U.S. General Services Administration (GSA) Website; www.gsa.gov.

4. CalOptima may reimburse additional lodging expenses for Non-Local Travel if:

a. It results in offsetting lower airfare; and

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

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

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

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

c. It is not practical or feasible for the authorized Individual to return home due to an extended commute.

6. Once approved, the Individual or his or her designee shall be responsible for making his or her own travel and lodging arrangements, utilizing the CalOptima travel services provider or another method approved by CalOptima's Purchasing Department.

7. The Individual shall be responsible for necessary cancellation of travel and lodging reservations, in accordance with the respective rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any cancellations.

I. Cash advances

1. Under normal circumstances, CalOptima shall not issue cash advances for Travel Expenses.

2. The Executive Management team shall approve cash advances for anticipated authorized travel.

3. CalOptima may authorize cash advances on a limited basis if the traveling Individual does not possess sufficient means of credit or other financial resources to cover the cost of one (1) or more authorized Travel Expenses, as defined in this policy.

4. When authorized, cash advances shall be based on an estimate of reasonable Travel Expenses, including travel, meals, lodging and miscellaneous expenses.

5. Individuals receiving cash advances shall complete an Expense Report within five (5) business days of the Individual's return to home or place of work, whichever occurs first. The Individual shall account for all expenses incurred while traveling on authorized CalOptima Business, and shall indicate any cash amounts due back to CalOptima, in the event the cash advance was greater than actual authorized expenses, or cash amounts due the Individual, in the event actual authorized expenses exceed the amount of the cash advance.

J. Transportation

1. The mode of transportation shall be based on the distance of the final destination from the Individual's home or primary workplace, business schedule, and the cost effectiveness of the various modes of transportation.

2. Cost of arrangements for personal travel in conjunction with a business travel itinerary will be at the authorized Individual's expense. The Individual shall document the incremental travel costs assessed to CalOptima, in accordance with this policy.

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

    a. Flight arrangements made through CalOptima's travel services provider shall be reviewed by CalOptima's Purchasing Department, and submitted directly to Accounts Payable for payment.

    b. Flight arrangements not made through the CalOptima travel services provider shall be submitted by the Individual on an Expense Report.

    c. Individuals may, for personal convenience, travel to their final destination on an indirect route, or on an interrupted direct route, if approved in advance by the CEO. An Individual shall pay any increase in transportation fares based on indirect or interrupted direct travel routes. Any resulting excess travel time shall not be considered work time, but shall be charged to the appropriate type of leave.

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

    e. Whenever available, all Individuals shall travel via "Coach Class," or similar reduced fare accommodations. "Business Class" reservations shall not be used except in the event that "Coach Class" or similar reduced fare accommodations are unavailable, and departure time is critical to the nature of the reason for travel. Under no circumstances shall "First Class" travel be reserved.

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

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

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

5. Use of Privately-Owned Vehicles

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

b. CalOptima shall reimburse the use of privately-owned vehicles solely based on actual mileage at the Internal Revenue Service (IRS) Standard Mileage Rate. Total mileage reimbursed should consider the Individual's daily commute.

c. CalOptima shall not reimburse costs for fuel, automobile repairs, or other automobile expense items.

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

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

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

6. Rental Automobiles

a. An Individual may rent automobile when such rental is considered to be more advantageous to CalOptima than other means of transportation.

b. Advance reservations shall be made whenever possible. Reservations for employees, Board and Committee members shall be made in the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

c. The vehicle rental agreement for the authorized Individual shall reference the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

d. Rental automobile approved classes are as follows:

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

ii. Mid-size Class: An Individual may select a mid-size class vehicle in the event more than four (4) individuals will be riding in the rental automobile at any one (1) time, or in the event an economy class vehicle is not available, and the nature of the travel requires immediate departure.

iii. Luxury Class: Under no circumstances shall an Individual select a luxury class vehicle.

7. Other Modes of Transportation

a. Taxi Fares: CalOptima shall reimburse taxi fares when public transportation is not practical or available. Examples include travel between hotel and place of business, and from one business to another.

III. PROCEDURE

A. Travel and Training Authorization Form

1. Shall be accessed and completed on-line by all Individuals or their designee using CalOptima's Intranet system (or similar system in place at the time request is made), and shall include all actual or estimated expense amounts related to the request; and

2. Shall be routed for approval systemically based on the Individual's level, cost center, and whether they are a CalOptima employee according to the following:

Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee
CEO	Board Chairperson or designee
Board Member/Standing Committee Member	Board Chairperson, CEO or designee

3. Shall also be routed systemically to the Human Resources Department in order to track the Individual's training.

4. Shall also be routed systemically to the Finance Department for confirmation that requested expenses are budgeted, and that enough budget remains to cover requested expenses.

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

6. The Purchasing Department shall review, authorize for appropriate approvals, and notify the requestors that they may begin making travel commitments.

B. Travel and Training Arrangements

1. Authorizations that include event registration fees shall be pre-paid and processed by CalOptima's Purchasing Department, where possible. CalOptima's Purchasing Department shall verify with the requestor that the registration has not been processed before proceeding with registration of the Individual for the event.

2. The requestor, or his or her designee, shall make air travel arrangements through CalOptima's travel services provider, where possible. Arrangements should be made as far in advance as possible to minimize costs. Exceptions to using CalOptima's travel services provider are subject to approval by CalOptima's Purchasing Department.

3. All other arrangements shall be made with the Individual's personal credit card, either through CalOptima's travel services provider, another approved method, or directly with the establishment(s), subject to CalOptima's Purchasing Department approval.

C. Expense Reimbursement using Expense Report

1. Individuals or designees shall prepare and submit request claims for reimbursement of Travel Expenses on a CalOptima Expense Report. The report shall be completed by the Individual or designee, including all details, and shall be routed with a copy of the previously-approved Travel and Training Authorization Form for appropriate Expense Report approval signatures, if applicable, as follows:

Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee*
CEO	Board Chairperson or designee*
Board Member/Standing Committee Member	Board Chairperson, CEO or designee*

*Designee authorization is not valid when self approval would result.

2. Receipts

   a. For any expenses in excess of twenty-five dollars ($25.00), the Individual shall include an original credit card receipt, if available, or other computer-generated or hand-written receipt, in the event a credit card receipt is unavailable. CalOptima contractors authorized to receive reimbursement for expenses shall submit receipts for all expenses, regardless of the dollar amount of the expenditure.

   b. Small receipts, such as credit card, gas and airline receipts, shall be attached to an 8 ½ by 11 inch sheet of paper. Hotel receipts and other larger receipts may be submitted as is.

   c. In the absence of credit card receipts, or other proof of actual expenditure, CalOptima shall reimburse lodging expenses only if marked "paid" by the management of the lodging facility.

   d. In most instances, airfare for CalOptima employees and Board members shall be prepaid by CalOptima. CalOptima contractors authorized to receive reimbursement for airfare, and employees and Board members for whom airfare was not prepaid for any reason, shall submit passenger receipts for reimbursement consideration.

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

3. Completed and approved Expense Reports and supporting documentation shall be submitted to the Accounting Department in a timely manner, preferably within thirty (30) days of completion of travel.

4. No reimbursement shall be made for Expense Reports submitted beyond six (6) months after completion of travel.

D. The Accounting Department shall:

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

2. Code expenses to appropriate department and general ledger account numbers; and

3. Process payment for reimbursement.

E. The Purchasing Department shall:

1. Provide travel reports to the CEO, Executive Management, and Department Directors, upon request. Such reports may include a summary of travel by department, purpose, cost, and number of individuals per event, and may be required to distinguish between budgeted and non-budgeted travel.

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

3. Attach appropriate copies of completed Travel and Training Authorization Forms related to travel service provider invoice line items, and submit to Accounts Payable for payment.

4. Review details of statements/invoices received from credit card account used by Purchasing to arrange attendance at conferences, training, and other events, and to make authorized purchases.

5. Attach appropriate copies of completed Travel and Training Authorization Forms related to credit card invoice travel and training line items, and submit to Accounts Payable for payment.

IV. ATTACHMENTS

A. Electronic Travel and Training Authorization Form
B. CalOptima Expense Report
C. Cash Advance Form

V. REFERENCES

A. Internal Revenue Service Publication 463
B. California Government Code Section 53232.2
C. Bylaws of Orange County Health Authority dba Orange Prevention and Treatment Integrated Medical Assistance, Adopted December 6, 1994

VI. APPROVALS OR BOARD ACTION

9/6/12: CalOptima Regular Board Meeting

VII. REVISION HISTORY

A. 9/6/12: GA.5004: Travel Policy
B. 8/1/12: GA.5004: Travel Policy

VIII. KEYWORDS

Approved Lodging
CalOptima Business
Executive Management

Expense Report
Individual
Local Travel
Lodging
Meals
Miscellaneous Expenses
Non-Local Travel
Non-Reimbursable Expenses
Parking, Fees and Tolls
Registration Fees
Reimbursable Expenses
Transportation
Travel
Travel and Training Authorization Form
Travel Expenses

Exhibit D

MEDI-CAL DATA ACCESS AGREEMENT

As a condition of obtaining access to information concerning procedures or other data records utilized/maintained by the Department of Health Care Services and CalOptima, Edelstein, Gilbert, Robson & Smith, 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.

CONTRACTOR 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.

CONTRACTOR 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.

CONTRACTOR further agrees that this Medi-Cal Data Access Agreement shall remain in full force and effect after the termination of this Contract.

By: _____ Date: August 16, 2018

Print Name: Trent E. Smith

Title: Manager

Exhibit E
Part 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that :

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Edelstein Gilbert Robson + Smith, LLC
Name of Contractor

Treat E. Smith
Printed Name of Person Signing for Contractor

Contract No. 18-10701
Contract/Grant Number

Signature of Person Signing for Contractor

August 16, 2018
Date

Manager
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

Exhibit I

Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: Edelstein Gilbert Robson & Smith, LLC

Business Entity Type: Limited Liability Corporation
(Sole Proprietorship, Partnership, LLC, California Corporation, etc.)

Business Address: 1127 11th St, Ste. 1030

City: Sacramento State: CA Zip: 95814

Business Phone: 916-443-6400 Email: : trent@egrslobby.com

President: _____ Contact Person: Trent E. Smith

Person(s) Signing Contract & Title: : Trent E. Smith, Manager

*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 %
Donald B. Gilbert	Manager 40.5 %
Michael R. Robson	Manager 31 %
Trent E. Smith	Manager 28.5 %

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.

Authorized Signature — August 16, 2018 Date

Trent E. Smith, Manager
Name and Title

Exhibit J

Not applicable for this Contract

Exhibit K

Not applicable for this Contract

Exhibit L

Not applicable for this Contract

AMENDMENT NO. 1 TO CONTRACT NO. 18-10701

BY AND BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY,
DBA ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE,
DBA CALOPTIMA
(CalOptima)

AND

EDELSTEIN, GILBERT, ROBSON & SMITH
(CONTRACTOR)

AMENDMENT NO. 1 TO THIS CONTRACT is entered into as of July 1, 2019, with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter collectively referred to as "the Parties") entered into Contract 18-10701 on September 4, 2018 for State Legislative Advocacy Services.

B. The Parties desire to amend the Contract to take advantage of the first (1st) of the four (4) extended terms available per Section 15 Of the Contract.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Amend Section 15 of the Contract to extend the termination date to June 30, 2020.

2. All other terms and conditions of the Contract remain unchanged.

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment on the day and year last shown below.

EDELSTEIN, GILBERT, ROBSON & SMITH

By: _____

Print Name: Trent Smith

Its: Partner

Date: 8/1/2019

CALOPTIMA

By: _____

Print Name: Michael Schrader

Its: Chief Executive Officer

Date: 8-2-19

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AMENDMENT NO. 2 TO CONTRACT NO. 18-10701

BY AND BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY,
DBA ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE,
DBA CALOPTIMA
(CalOptima)

AND

EDELSTEIN, GILBERT, ROBSON & SMITH
(CONTRACTOR)

AMENDMENT NO. 2 TO THIS CONTRACT is entered into as of July 1, 2020, with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter collectively referred to as "the Parties") entered into Contract 18-10701 on September 4, 2018 for State Legislative Advocacy Services. Amendment No. 1 was entered into as of July 1, 2019.

B. The Parties desire to amend the Contract to take advantage of the second (2nd) of the four (4) extended terms available per Section 15 Of the Contract.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Amend Section 15 of the Contract to extend the termination date to June 30, 2021.

2. All other terms and conditions of the Contract remain unchanged.

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment on the day and year last shown below.

EDELSTEIN, GILBERT, ROBSON & SMITH

By: _____

Print Name: Trent Smith

Its: Partner, EGRS

Date: 8/10/2020

CALOPTIMA

DocuSigned by:

By : Richard Sanchez
234AD421BDEC4D9...

Print Name: Richard Sanchez

Its: Interim Chief Executive Officer

Date: 08/24/2020

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AMENDMENT NO. 3 TO CONTRACT NO. 18-10701
BY AND BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, DBA
CALOPTIMA
(CalOptima)
AND
EDELSTEIN, GILBERT, ROBSON & SMITH
(CONTRACTOR)

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

A. CalOptima and CONTRACTOR (hereinafter collectively referred to as "the Parties") entered into Contract 18-10701 on September 4, 2018 for State Legislative Advocacy Services.

B. Amendment No. 1 was entered into as of July 1, 2019, and Amendment No. 2 was entered into as of July 1, 2020.

C. Pursuant to Section 17 of the Contract, the Contract may be amended only in writing and executed by both parties.

D. The Parties now desire to extend the Contract.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Pursuant to Section 15 of the Contract, the third of four Extended Terms is hereby executed to extend the Contract Term to June 30, 2022.

2. **No Other Changes**. This Amendment No. 3 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. 3 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.

[Signature to follow on next page]

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IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 3 to Contract 18-10701 on the day and year last shown below.

EDELSTEIN, GILBERT, ROBSON & SMITH

Signature: _____

Print Name: Trent Smith

Title: Partner/Manager

Date: 4/8/2021

Signature: _____

Print Name: _____

Title: _____

Date: _____

CALOPTIMA

DocuSigned by:

Signature: Nancy Huang
D22E3B87032946F...

Print Name : Nancy Huang

Title: CFO, CalOptima

Date: 05/17/2021

DocuSigned by:

Signature: Richard Sanchez
234AD421BDEC4D9...

Print Name : Richard Sanchez

Title: CEO, CalOptima

Date: 05/17/2021

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AMENDMENT NO. 4 TO CONTRACT NO. 18-10701
BY AND BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, DBA
CALOPTIMA
(CalOptima)
AND
EDELSTEIN, GILBERT, ROBSON & SMITH
(CONTRACTOR)

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

A. CalOptima and CONTRACTOR (hereinafter collectively referred to as "the Parties") entered into Contract 18-10701 on September 4, 2018 for State Legislative Advocacy Services.

B. Amendment No. 1 was entered into as of July 1, 2019, Amendment No. 2 was entered into as of July 1, 2020, and Amendment No. 3 was entered into on 5/17/2021.

C. Pursuant to Section 17 of the Contract, the Contract may be amended only in writing and executed by both parties.

D. The Parties now desire to extend the Contract, and to add an additional service.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Pursuant to Section 15 of the Contract, the fourth of four Extended Terms is hereby executed to extend the Contract Term to June 30, 2023.

2. CONTRACTOR shall pass-through fees for quarterly preparation and submission of State Lobbying Disclosures, at a quarterly cost of One Hundred Fifty Dollars ($150.00), totaling an annual cost of Six Hundred Dollars ($600.00).

3. **No Other Changes**. This Amendment No. 4 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. 4 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.

[Signature to follow on next page]

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IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 4 to Contract 18-10701 on the day and year last shown below.

EDELSTEIN, GILBERT, ROBSON & SMITH

Signature: _____

Print Name: Trent Smith

Title: Partner

Date: 4/12/2022

Signature: _____

Print Name: _____

Title: _____

Date: _____

CALOPTIMA

DocuSigned by:

Signature: Nancy Huang
D22E3B87032946F...

Print Name : Nancy Huang

Title: CFO, CalOptima

Date: 06/22/2022

DocuSigned by:

Signature: Michael Hunn
EDDDDCC19C894FB...

Print Name : Michael Hunn

Title: CEO

Date: 06/23/2022

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Exhibit A
SCOPE OF WORK

Purpose
CONTRACTOR shall represent CalOptima's interests, as specified below, in Sacramento and have the responsibility of monitoring and influencing legislative and regulatory policies, building and maintaining positive and mutually beneficial relationships with officials, and providing CalOptima with necessary advocacy services.

Reporting Relationship
The Chief Executive Officer; Chief Operating Officer; Chief of Staff; Senior Director, State Government Affairs; and Senior Manager, Government Affairs; and/or their designee(s), will be the primary contacts and will direct the work of the CONTRACTOR.

Objectives/Deliverables
CONTRACTOR agrees to provide to CalOptima, as requested by CalOptima, the following services:

1. Register and serve as a legislative advocate for CalOptima pursuant to the rules and procedures of the Fair Political Practices Commission and any other necessary entities for which registration may be necessary.

2. Regularly consult with CalOptima's primary contacts and other contracted advocacy firms regarding CalOptima's government affairs program.

3. Develop a robust, proactive advocacy strategy with CalOptima's Government Affairs Department, Executive Office, and Board, including by providing ongoing legislative/political analysis and strategic and tactical recommendations regarding CalOptima's advocacy priorities and activities.

4. Maintain regular contact with leadership and staff of the government of the State of California, including but not limited to the following entities:
    - California State Legislature;
    - Governor's Office;
    - California Health and Human Services Agency (CalHHS);
    - Department of Health Care Services (DHCS);
    - Department of Managed Health Care (DMHC);
    - Department of Health Care Access and Innovation (HCAI); and
    - Any other state departments, agencies, boards, and commissions, when directed by CalOptima.

5. Prioritize the development of relationships with state legislators who represent any portion of Orange County, as well as any staff thereof, to improve their awareness and positive perception of CalOptima, secure their alignment with and advocacy for CalOptima's positions, and improve opportunities for current and future collaboration.

6. As directed by CalOptima, brief Orange County's legislative delegation with CalOptima updates, publications and other informational items. These may include the annual Report to the Community, Fast Facts, and other materials.

7. Arrange meetings and briefings for CalOptima Board and staff with state officials and staff. CONTRACTOR shall be proactive in scheduling strategic, targeted meetings and briefings, especially but not limited to times when CalOptima Board and staff are scheduled to be in Sacramento. Meetings and briefings may include formal briefings, as well as informal social meetings, as appropriate.

8. Notify CalOptima of anticipated, introduced or amended state legislation, as well as proposed and final administrative, budgetary, and regulatory actions which could impact CalOptima. These activities include but are not limited to the following:
    - Providing the bill number and brief summary of introduced or amended state legislation;

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- Providing copies of legislation, committee analysis, and any other relevant analyses;
- Providing information relative to legislative hearings;
- Providing a brief summary of proposed and final administrative, budgetary, and regulatory actions; and
- Providing recommendations regarding CalOptima's response, engagement, and advocacy.

9. Identify new program and funding opportunities that relate to CalOptima.

10. Advocate for CalOptima's programs, positions on legislation introduced in the California State Legislature, and administrative, budgetary, and regulatory proposals introduced by state agencies and the Governor's Office. Advocacy activities include but are not limited to the following:
    - Developing and implementing an advocacy strategy;
    - Coordinating and engaging in virtual and in-person meetings;
    - Drafting and submitting written letters of support and opposition;
    - Drafting bill amendments to proposed legislation, as well as circulating and securing support for such amendments from legislators and their staff;
    - Identifying witnesses, preparing written testimony, and delivering verbal testimony as directed before committees of the Legislature; and
    - Creating and leading necessary advocacy coalitions.

11. Proactively identify and engage in additional opportunities for CalOptima to influence state legislative, regulatory, budgetary, and administrative proposals and policymaking processes for the benefit of CalOptima.

12. Maintain relationships with, and engage in partnership opportunities with, trade associations and other health care and non-health care organizations to advance CalOptima's shared advocacy priorities.

13. Provide monthly, written reports which shall include a state budget and legislative update, as well as a description of the nature and extent of services or actions taken on behalf of CalOptima. The services and actions shall include a summary of the CONTRACTOR's meetings along with the issues discussed with members of the California State Legislature, legislative staff, and relevant committee staff, as well as appropriate state departments, agencies, boards, commissions, committees, and staff. The reports shall be delivered on a schedule as directed by CalOptima staff and may be included in the CalOptima Board book and/or provided to Board members. The frequency of written reports may be modified at any time.

14. Provide in-person or over-the-phone briefings, as directed by CalOptima staff, to the CalOptima Board and executive staff.

15. Provide copies of all written correspondence, testimony, and position papers given on behalf of CalOptima, as well as access to the state budget and any related documents (including but not limited to DHCS and Legislative Analyst's Office analyses) as they become available.

CalOptima staff may prepare a formal annual review of CONTRACTOR's work product at the end of each calendar/fiscal year.

Performance of Duties
CONTRACTOR agents shall faithfully, industriously, and to the best of their ability, experience, and talents, perform all of the duties that may reasonably be assigned to him or her hereunder and devote such time to the performance of such duties as may be necessary, therefore.

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
15. Adopt the Proposed CalOptima Health Board of Directors Meeting Schedule for Fiscal Year 2023-24

Contact
Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Action
Adopt the proposed meeting schedule of the CalOptima Health Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee for the period of July 1, 2023 through June 30, 2024.

Background
Section 5.2(b)(1) of the CalOptima Health Bylaws specifies that the Board shall conduct an annual organizational meeting at a regular meeting to be designated in advance by the Board. The annual organizational meeting is scheduled for the June Board meeting each year. At the annual organizational meeting, the Board shall adopt a schedule stating the dates, times, and places of the Board's regular meetings for the following year.

Discussion
The proposed schedule of meetings for the period of July 1, 2023 through June 30, 2024 is as follows:

1. The Board of Directors will meet at 2:00 p.m. on the first Thursday of each month, with the following exceptions:
   - Due to the Independence Day holiday, staff recommends that the Board consider not meeting in July. Should unanticipated items arise during July 2023 that require Board review/approval, the Chief Executive Officer (CEO) will confer with the Board Chair or Vice Chair, and items will be presented for ratification at the following regularly scheduled Board meeting.

   - Due to the New Year's holiday, staff recommends that the Board consider not meeting in January 2024. Should unanticipated items arise during January requiring Board review/approval, the CEO will confer with the Board Chair or Vice Chair, and items will be presented for ratification at the following regularly scheduled Board meeting.

2. The Finance and Audit Committee will meet quarterly at 3:00 p.m. on the third Thursday in the months of September, November, February, and May.

3. The Quality Assurance Committee will meet quarterly at 3:00 p.m. on the second Wednesday in the months of September, December, March, and June.

The meetings of the Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee are held at the CalOptima Health offices located at 505 City Parkway West, 1st Floor,

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Orange, California, unless notice of an alternate location is provided. The proposed Fiscal Year (FY) 2023-24 Board of Directors Meeting Schedule is attached.

Fiscal Impact

The fiscal impact for FY 2023-24 Board of Directors Meetings is up to $18,000 in per diem costs and mileage reimbursement for certain Board members. Funding is included as part of the proposed CalOptima Health FY 2023-24 Operating Budget pending Board approval.

Rationale for Recommendation

The recommended action will confirm the Board's meeting schedule for the next fiscal year as required in Section 5.2 of the Bylaws.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Proposed Schedule of Meetings of the CalOptima Health Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee – July 1, 2023 through June 30, 2024

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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Board of Directors Meeting Schedule
July 1, 2023 – June 30, 2024

All meetings are held at the following location, unless notice of an alternate location is provided:

505 City Parkway West
Orange, California 92868

Board of Directors **Monthly – First Thursday** **Meeting Time: 2:00 p.m.**	**Finance and Audit Committee** **Quarterly – Third Thursday** **Meeting Time: 3:00 p.m.**	**Quality Assurance Committee** **Quarterly – Second Wednesday** **Meeting Time: 3:00 p.m.**
July 2023^		
August 3, 2023		
September 7, 2023	September 21, 2023	September 13, 2023
October 5, 2023		
November 2, 2023	November 16, 2023	
December 7, 2023		December 13, 2023
January 2024^		
February 1, 2024	February 15, 2024	
March 7, 2024		March 13, 2024
April 4, 2024		
May 2, 2024	May 16, 2024	
June 6, 2024[1]		June 12, 2024

^No Regular meeting scheduled
[1] Organizational Meeting

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Financial Summary

April 30, 2023

Board of Directors Meeting
June 1, 2023

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.

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Financial Highlights: April 2023

April					July to April			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
984,986	904,826	80,160	8.9%	Member Months	9,525,453	9,119,235	406,218	4.5%
348,999,375	327,387,553	21,611,822	6.6%	Revenues	3,472,811,712	3,329,332,586	143,479,126	4.3%
308,989,504	307,082,756	(1,906,748)	(0.6%)	Medical Expenses	3,214,447,060	3,121,837,529	(92,609,531)	(3.0%)
15,675,690	18,766,126	3,090,436	16.5%	Administrative Expenses	151,833,358	180,917,657	29,084,299	16.1%
24,334,181	**1,538,671**	**22,795,510**	**1481.5%**	**Operating Margin**	**106,531,294**	**26,577,400**	**79,953,894**	**300.8%**
				Non-Operating Income (Loss)				
12,002,821	500,000	11,502,821	2300.6%	Net Investment Income/Expense	74,080,087	5,000,000	69,080,087	1381.6%
77,068	90,835	(13,767)	(15.2%)	Net Rental Income/Expense	837,999	908,350	(70,351)	(7.7%)
(2,917)	-	(2,917)	(100.0%)	Net MCO Tax	17,937	-	17,937	100.0%
(863,636)	(2,077,922)	1,214,286	58.4%	Grant Expense	(23,636,364)	(15,844,154)	(7,792,210)	(49.2%)
-	-	-	0.0%	Net QAF/IGT Income/Expense	-	-	-	0.0%
30	-	30	100.0%	Other Income/Expense	105	-	105	100.0%
11,213,366	**(1,487,087)**	**12,700,453**	**854.0%**	**Total Non-Operating Income (Loss)**	**51,299,764**	**(9,935,804)**	**61,235,568**	**616.3%**
35,547,547	**51,584**	**35,495,963**	**68812.0%**	**Change in Net Assets**	**157,831,058**	**16,641,596**	**141,189,462**	**848.4%**
88.5%	93.8%	(5.3%)		Medical Loss Ratio	92.6%	93.8%	(1.2%)	
4.5%	5.7%	1.2%		Administrative Loss Ratio	4.4%	5.4%	1.1%	
7.0%	0.5%	6.5%		Operating Margin Ratio	3.1%	0.8%	2.3%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
88.5%	93.8%	(5.3%)		*MLR (excluding Directed Payments)	91.9%	93.8%	(1.9%)	
4.5%	5.7%	1.2%		*ALR (excluding Directed Payments)	4.8%	5.4%	0.7%	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

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CalOptima Health

Consolidated Performance: April 2023 (in millions)

April				July-April		
Actual	Budget	Variance	Operating Income (Loss)	Actual	Budget	Variance
22.2	2.2	20.0	Medi-Cal	108.4	36.5	71.8
(0.9)	(0.0)	(0.8)	OCC	(1.6)	(3.1)	1.4
2.8	(0.7)	3.5	OneCare	(1.0)	(6.6)	5.6
0.3	0.2	0.1	PACE	1.5	0.1	1.4
(0.1)	(0.0)	(0.0)	MSSP	(0.7)	(0.4)	(0.3)
24.3	**1.5**	**22.8**	**Total Operating Income (Loss)**	**106.5**	**26.6**	**80.0**
			Non-Operating Income (Loss)			
12.0	0.5	11.5	Net Investment Income/Expense	74.1	5.0	69.1
0.1	0.1	(0.0)	Net Rental Income/Expense	0.8	0.9	(0.1)
(0.0)	0.0	(0.0)	Net Operating Tax	0.0	0.0	0.0
(0.9)	(2.1)	1.2	Grant Expense	(23.6)	(15.8)	(7.8)
0.0	0.0	0.0	Other Income	0.0	0.0	0.0
11.2	**(1.5)**	**12.7**	**Total Non-Operating Income/(Loss)**	**51.3**	**(9.9)**	**61.2**
35.5	**0.1**	**35.5**	**TOTAL**	**157.8**	**16.6**	**141.2**

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CalOptima Health

FY 2022-23: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) April 2023: $35.5 million, favorable to budget $35.5 million or 68,812.0%
  - Year To Date (YTD) July 2022– April 2023: $157.8 million, favorable to budget $141.2 million or 848.4%
- Enrollment
  - MTD: 984,986 members, favorable to budget 80,160 or 8.9%
  - YTD: 9,525,453 members, favorable to budget 406,218 or 4.5%
  - Favorable enrollment primarily driven by a pause in Medi-Cal redetermination due to the extension of the COVID-19 Public Health Emergency (PHE) until May 11, 2023

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Revenue
  - MTD: $349.0 million, favorable to budget $21.6 million or 6.6% driven by Medi-Cal Line of Business (MC LOB):
    - $135.4 million from the release of the Adult Expansion Medical Loss Ratio (MLR) accruals for the period of January 1, 2014 through June 30, 2017 after receiving the review completion notice from the Department of Health Care Services (DHCS) and $31.8 million from favorable volume and price variances
    - Offset by $142.1 million due to updates to the COVID-19 risk corridor calculation, $4.5 million due to Enhanced Care Management (ECM) and Proposition 56 risk corridor reserves
  - YTD: $3,472.8 million, favorable to budget $143.5 million or 4.3% driven by MC LOB:
    - $293.6 million of Hospital Directed Payments (DP), $135.4 million of prior period MLR accrual release and $190.7 million primarily from favorable volume related variance and premium capitation rates
    - Offset by $489.2 million due to COVID-19, Proposition 56 and ECM risk corridor reserves

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Medical Expenses
  - MTD: $309.0 million, unfavorable to budget $1.9 million or 0.6% driven by MC and OneCare Connect (OCC) LOB's:
    - Incentive Payments expense unfavorable variance of $14.9 million primarily due to Housing and Homelessness Incentive Program (HHIP)
    - Professional Claims expense unfavorable variance of $5.1 million
    - Provider Capitation expense unfavorable variance of $3.4 million
    - Offset by:
      - Facilities Claims expense favorable variance of $8.5 million
      - Managed Long-Term Services and Supports (MLTSS) favorable variance of $8.1 million due to lower than budgeted utilization
      - OCC Medical Expenses favorable variance of $1.8 million primarily due to prior period pharmacy rebates

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FY 2022-23:Management Summary (cont.)

- Medical Expenses
  - YTD: $3,214.4 million, unfavorable to budget $92.6 million or 3.0% driven by MC LOB:
    - Other Medical Expenses and Incentive payment unfavorable variance of $300.3 million due to Hospital DP
    - Offset by:
      - Provider Capitation favorable variance of $112.6 million primarily due to updated logic for Proposition 56
      - MLTSS favorable variance of $58.1 million due to lower than budgeted utilization
      - Favorable variances totaling $46.4 million from Facilities Claims, Professional Claims, Prescription Drugs, and Medical Management due to lower than budgeted utilization

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FY 2022-23:Management Summary (cont.)

- Administrative Expenses
  - MTD: $15.7 million, favorable to budget $3.1 million or 16.5%
    - Other Non-Salary expenses favorable variance of $2.6 million
    - Salaries & Benefits expense favorable variance of $0.5 million
  - YTD: $151.8 million, favorable to budget $29.1 million or 16.1%
    - Other Non-Salary expenses favorable variance of $19.3 million
    - Salaries & Benefits expense favorable variance of $9.8 million

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FY 2022-23:Management Summary (cont.)

- Non-Operating Income (Loss)
  - MTD: $11.2 million, favorable to budget $12.7 million or 854.0%
    - Non-operating favorable variance is primarily due to Net Investment Income of $11.5 million and Grant Expense of $1.2 million
  - YTD: $51.3 million, favorable to budget $61.2 million or 616.3%
    - Non-operating favorable variance is primarily due to Net Investment Income of $69.1 million, offset by Grant Expense of $7.8 million

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CalOptima Health

FY 2022-23: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 88.5% (88.5% excluding DP), Budget 93.8%
  - YTD: Actual 92.6% (91.9% excluding DP), Budget 93.8%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 4.5% (4.5% excluding DP), Budget 5.7%
  - YTD: Actual 4.4% (4.8% excluding DP), Budget 5.4%
- Balance Sheet Ratios
  - *Current ratio: 1.5
  - Board-designated reserve level: 1.91
  - Net-position: $1.6 billion, including required Tangible Net Equity (TNE) of $105.3 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: April 2023

April					July to April			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
141,452	138,812	2,640	1.9%	SPD	1,313,420	1,289,686	23,734	1.8%
306,307	302,660	3,647	1.2%	TANF Child	3,042,851	3,051,147	(8,296)	(0.3%)
141,973	127,389	14,584	11.4%	TANF Adult	1,369,017	1,325,792	43,225	3.3%
3,233	3,501	(268)	(7.7%)	LTC	32,184	33,962	(1,778)	(5.2%)
362,563	303,220	59,343	19.6%	MCE	3,472,386	3,124,375	348,011	11.1%
11,618	11,872	(254)	(2.1%)	WCM	118,028	117,948	80	0.1%
967,146	**887,454**	**79,692**	**9.0%**	**Medi-Cal Total**	**9,347,886**	**8,942,910**	**404,976**	**4.5%**
		0	**0.0%**	**OneCare Connect**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
17,406	**16,876**	**530**	**3.1%**	**OneCare**	**87,045**	**83,721**	**3,324**	**4.0%**
434	**496**	**(62)**	**(12.5%)**	**PACE**	**4,337**	**4,717**	**(380)**	**(8.1%)**
473	**568**	**(95)**	**(16.7%)**	**MSSP**	**4,724**	**5,680**	**(956)**	**(16.8%)**
984,986	**904,826**	**80,160**	**8.9%**	**CalOptima Health Total**	**9,525,453**	**9,119,235**	**406,218**	**4.5%**

*CalOptima Health Total does not include MSSP

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CalOptima Health

Consolidated Revenue & Expenses: April 2023 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	592,965	362,563	11,618	967,146		17,406	434	473	984,986
REVENUES									
Capitation Revenue	190,496,357	$ 106,568,974	$ 19,278,515	$ 316,343,845	$ (2,627,134)	$ 31,397,493	$ 3,674,281	$ 210,891	########
Total Operating Revenue	190,496,357	106,568,974	19,278,515	316,343,845	(2,627,134)	31,397,493	3,674,281	210,891	348,999,375
MEDICAL EXPENSES									
Provider Capitation	46,696,211	52,911,614	7,066,987	106,674,812	22	12,590,206			119,265,040
Facilities	26,687,108	25,141,412	6,961,283	58,789,803	3,994	4,857,895	642,137		64,293,829
Professional Claims	27,186,587	17,015,891	2,042,394	46,244,872	20,225	1,252,081	1,022,276		48,539,453
Prescription Drugs	(962,465)			(962,465)	(1,630,439)	6,554,807	413,076		4,374,978
MLTSS	38,463,650	4,771,263	960,806	44,195,718	(186,040)	80,601	33,233	31,160	44,154,671
Incentive Payments	11,135,495	8,114,130	217,682	19,467,307	(51,238)	271,433			19,687,502
Medical Management	2,982,274	1,446,831	387,855	4,816,960	23,881	1,163,793	1,033,643	168,428	7,206,705
Other Medical Expenses	907,664	541,488	18,175	1,467,326					1,467,326
Total Medical Expenses	153,096,523	109,942,628	17,655,180	280,694,332	(1,819,596)	26,770,817	3,144,363	199,588	308,989,504
Medical Loss Ratio	80.4%	103.2%	91.6%	88.7%	69.3%	85.3%	85.6%	94.6%	88.5%
GROSS MARGIN	**37,399,833**	**(3,373,655)**	**1,623,335**	**35,649,513**	**(807,538)**	**4,626,676**	**529,918**	**11,303**	**40,009,871**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				9,392,654	25,351	779,856	139,787	81,777	10,419,426
Professional Fees				487,558	13,238	20,833	1,354	1,333	524,317
Purchased Services				1,032,424	(3,039)	141,431	73,971	5	1,244,792
Printing & Postage				422,512	9,376	24,063	5,217		461,169
Depreciation & Amortization				367,043			1,097		368,140
Other Expenses				2,248,828	1,416	5,033	20,812	8,009	2,284,098
Indirect Cost Allocation, Occupancy				(530,587)		884,890	13,932	5,513	373,748
Total Administrative Expenses				**13,420,433**	**46,342**	**1,856,107**	**256,170**	**96,638**	**15,675,690**
Admin Loss Ratio				4.2%	-1.8%	5.9%	7.0%	45.8%	4.5%
INCOME (LOSS) FROM OPERATIONS				22,229,080	(853,881)	2,770,569	273,747	(85,335)	24,334,181
INVESTMENT INCOME									12,002,821
NET RENTAL INCOME									77,068
TOTAL MCO TAX				(2,917)					(2,917)
TOTAL GRANT EXPENSE				(863,636)					(863,636)
OTHER INCOME				30					30
CHANGE IN NET ASSETS				**$ 21,362,557**	**$ (853,881)**	**$ 2,770,569**	**$ 273,747**	**$ (85,335)**	**$ 35,547,547**
BUDGETED CHANGE IN NET ASSETS				114,238	(41,387)	(737,750)	165,162	(39,514)	51,584
VARIANCE TO BUDGET - FAV (UNFAV)				$ 21,248,319	$ (812,494)	$ 3,508,319	$ 108,585	$ (45,821)	$ 35,495,963

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CalOptima Health

Consolidated Revenue & Expenses: April 2023 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	5,757,472	3,472,386	118,028	9,347,886	86,185	87,045	4,337	4,724	9,525,453
REVENUES									
Capitation Revenue	1,622,367,871	$ 1,265,374,329	$ 228,737,325	$ 3,116,479,525	$ 172,744,449	$ 145,272,589	$ 36,302,135	$ 2,013,015	$ 3,472,811,712
Total Operating Revenue	1,622,367,871	1,265,374,329	228,737,325	3,116,479,525	172,744,449	145,272,589	36,302,135	2,013,015	3,472,811,712
MEDICAL EXPENSES									
Provider Capitation	388,896,982	469,263,782	83,411,379	941,572,143	72,095,156	56,723,537			1,070,390,836
Facilities	321,455,605	282,802,151	53,694,604	657,952,359	26,987,617	26,018,312	7,778,136		718,736,424
Professional Claims	238,025,710	146,497,963	15,140,821	399,664,494	8,736,375	6,278,868	9,549,657		424,229,394
Prescription Drugs	(3,220,624)	(2,287,072)	5,604	(5,502,092)	37,735,773	41,605,659	4,138,078		77,977,419
MLTSS	384,773,043	44,681,013	18,664,555	448,118,611	9,603,761	321,073	1,396,440	288,845	459,728,729
Incentive Payments	38,970,587	39,839,182	1,020,947	79,830,716	2,345,716	725,217	(120,875)		82,780,775
Medical Management	28,678,135	19,501,190	4,260,737	52,440,062	6,818,551	4,628,833	9,946,177	1,545,626	75,379,248
Other Medical Expenses	162,588,902	124,039,715	18,595,618	305,224,234					305,224,234
Total Medical Expenses	1,560,168,340	1,124,337,924	194,794,265	2,879,300,529	164,322,948	136,301,499	32,687,613	1,834,471	3,214,447,060
Medical Loss Ratio	96.2%	88.9%	85.2%	92.4%	95.1%	93.8%	90.0%	91.1%	92.6%
GROSS MARGIN	**62,199,531**	**141,036,405**	**33,943,060**	**237,178,996**	**8,421,500**	**8,971,090**	**3,614,523**	**178,544**	**258,364,652**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				92,815,995	4,247,381	4,046,505	1,366,667	762,771	103,239,319
Professional Fees				6,072,348	24,884	250,291	4,461	13,333	6,365,317
Purchased Services				9,749,525	594,498	903,690	291,494	5	11,539,213
Printing & Postage				3,211,293	261,432	810,109	188,522		4,471,356
Depreciation & Amortization				3,701,287			8,222		3,709,508
Other Expenses				18,619,100	10,498	17,390	108,233	61,782	18,817,002
Indirect Cost Allocation, Occupancy				(5,351,707)	4,929,832	3,919,071	139,316	55,132	3,691,644
Total Administrative Expenses				**128,817,840**	**10,068,525**	**9,947,055**	**2,106,916**	**893,023**	**151,833,358**
Admin Loss Ratio				4.1%	5.8%	6.8%	5.8%	44.4%	4.4%
INCOME (LOSS) FROM OPERATIONS				108,361,156	(1,647,025)	(975,965)	1,507,607	(714,479)	106,531,294
INVESTMENT INCOME									74,080,087
NET RENTAL INCOME									837,999
TOTAL MCO TAX				17,937					17,937
TOTAL GRANT EXPENSE				(23,636,364)					(23,636,364)
OTHER INCOME				105					105
CHANGE IN NET ASSETS				**$ 84,742,834**	**$ (1,647,025)**	**$ (975,965)**	**$ 1,507,607**	**$ (714,479)**	**$ 157,831,058**
BUDGETED CHANGE IN NET ASSETS				20,693,339	(3,096,310)	(6,558,387)	126,215	(431,611)	16,641,596
VARIANCE TO BUDGET - FAV (UNFAV)				$ 64,049,495	$ 1,449,285	$ 5,582,422	$ 1,381,392	$ (282,868)	$ 141,189,462

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CalOptima Health

Balance Sheet: As of April 2023

ASSETS			**LIABILITIES & NET POSITION**		
Current Assets			Current Liabilities		
Operating Cash		$818,209,793	Accounts Payable		$9,214,218
Short-term Investments		1,504,383,432	Medical Claims Liability		1,699,079,684
Capitation Receivable		372,525,675	Accrued Payroll Liabilities		19,300,557
Receivables - Other		95,691,186	Deferred Revenue		7,805,892
Prepaid Expenses		20,738,393	Deferred Lease Obligations		52,304
			Capitation and Withholds		100,795,921
Total Current Assets		**2,811,548,478**	**Total Current Liabilities**		**1,836,248,575**
Capital Assets					
Furniture & Equipment		50,490,439			
Building/Leasehold Improvements		5,299,125			
Construction in Progress		5,982,063			
505 City Parkway West		52,965,722			
500 City Parkway West		22,631,500			
		137,368,849			
Less: Accumulated Depreciation		(70,229,278)	Other Liabilities		
Capital Assets, Net		67,139,571	GASB 96 Subscription Liabilities		-
GASB 96 Capital Assets			Other (than pensions) Post		
GASB 96 Subscription Assets		-	Employment Benefits Liability		22,607,827
			Net Pension Liabilities		577,854
Less: GASB 96 Accumulated Depreciation		-	Bldg 505 Development Rights		-
GASB 96 Capital Assets, Net		-			
Total Capital Assets		67,139,571			
Other Assets					
Restricted Deposit & Other		300,000	**TOTAL LIABILITIES**		**1,859,434,256**
Homeless Health Reserve		-			
Board-Designated Assets:					
Cash and Cash Equivalents		27,164			
Investments		579,882,780	Deferred Inflows		
Total Board-Designated Assets		579,909,944	Excess Earnings		686,563
			OPEB 75 Difference in Experience		4,822,000
			Change in Assumptions		1,909,305
Total Other Assets		580,209,944	OPEB Changes in Assumptions		3,389,000
			Diff in Proj vs Act		20,982,636
			Net Position		
TOTAL ASSETS		**3,458,897,993**	TNE		105,318,495
			Funds in Excess of TNE		1,471,981,331
Deferred Outflows			**TOTAL NET POSITION**		1,577,299,826
Contributions		1,931,845			
Difference in Experience		2,353,671			
Excess Earning		-			
Changes in Assumptions		2,325,077			
OPEB 75 Changes in Assumptions		2,486,000			
Pension Contributions		529,000			
TOTAL ASSETS & DEFERRED OUTFLOWS		**3,468,523,586**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**		**3,468,523,586**

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CalOptima Health

Board Designated Reserve and TNE Analysis: As of April 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	236,099,730				
	Tier 1 - MetLife	234,373,593				
Board-designated Reserve		470,473,324	318,978,450	500,819,997	151,494,874	(30,346,674)
	Tier 2 - Payden & Rygel	54,847,720				
	Tier 2 - MetLife	54,588,901				
TNE Requirement		109,436,620	105,318,495	105,318,495	4,118,126	4,118,126
	Consolidated:	**579,909,944**	**424,296,944**	**606,138,492**	**155,613,000**	**(26,228,548)**
	Current reserve level	*1.91*	*1.40*	*2.00*		

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CalOptima Health

Net Assets Analysis: As of April 2023

Category	Item Description	Amount (millions)	Approved Initiative	Spend to Date	%
	Total Net Position @ 4/30/2023	**$1,577.3**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**579.9**			**36.8%**
	Capital Assets, net of depreciation	**67.1**			**4.3%**
Resources Allocated[2]	Homeless Health Initiative[3]	$21.5	$59.9	$38.4	1.4%
	Housing and Homelessness Incentive Program[4]	40.8	52.7	11.9	2.6%
	Intergovernmental Transfers (IGT)	59.1	111.7	52.6	3.7%
	Digital Transformation and Workplace Modernization	91.5	100.0	8.5	5.8%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	Outreach Strategy for CalFresh, Redetermination support, and other programs	7.0	8.0	1.0	0.4%
	Coalition of Orange County Community Health Centers Grant	40.0	50.0	10.0	2.5%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	1.0	1.0	0.0	0.1%
	General Awareness Campaign	1.1	2.7	1.6	0.1%
	Member Health Needs Assessment	1.0	1.0	0.0	0.1%
	Five-Year Hospital Quality Program Beginning MY 2023	153.5	153.5	0.0	9.7%
	Medi-Cal Annual Wellness Initiative	15.0	15.0	0.0	1.0%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.6%
	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	5.0	5.0	0.0	0.3%
	Community Living and PACE Center in the City of Tustin	18.0	18.0	0.0	1.1%
	Subtotal:	**$466.5**	**$606.5**	**$140.0**	**29.6%**
Resources Available for New Initiative	Unallocated/Unassigned[1]	**$463.7**			**29.4%**

[1] Total of Board Designated reserve and unallocated reserve amount can support approximately 103 days of CalOptima Health's current operations

[2] Initiatives that have been paid in full in the previous year are omitted from the list of Resource Allocated

[3] See Page 30 for Summary of Homeless Health Initiative and Allocated Funds for list of Board approved initiatives

[4] On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP (see HHIP Summary on Page 31)

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CalOptima Health

Homeless Health Initiative and Allocated Funds: As of April 2023

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 & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,434,060	565,940
CalOptima Days, HCAP and FQHC Administrative Support	963,261	640,753	322,508
FQHC (Community Health Center) Expansion	21,902	21,902	-
Homeless Clinical Access Program (HCAP) and CalOptima Days	9,888,914	3,170,400	6,718,514
Vaccination Intervention and Member Incentive Strategy	400,000	54,649	345,351
Street Medicine	8,000,000	1,455,500	6,544,500
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)*	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$ 100,000,000**	**$ 38,403,187**	**$ 61,596,813**
Transfer of funds to HHIP	(40,100,000)	-	(40,100,000)
Program Total	**$ 59,900,000**	**$ 38,403,187**	**$ 21,496,813**

Note:

*On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP

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CalOptima Health

Housing and Homelessness Incentive Program
As of April 2023

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Office of Care Coordination	2,200,000	-	2,200,000
Pulse For Good	800,000	-	800,000
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations	3,021,311	1,396,149	1,625,162
Infrastructure Projects	5,832,314	2,577,032	3,255,282
Capital Projects	40,212,839	7,948,340	32,264,499
Total of Approved Initiatives	**$ 52,666,464**	**$ 11,921,521**	**$ 40,744,943**

Note:

Total funding $52.7M: $40.1M Board approved transfer from CalOptima Homeless Health Initiatives and $12.6M from DHCS HHIP incentive payment

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UNAUDITED FINANCIAL STATEMENTS

April 30, 2023

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CalOptima Health - Consolidated
Financial Highlights
For the Ten Months Ended April 30, 2023

April					July to April			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
984,986	904,826	80,160	8.9%	Member Months	9,525,453	9,119,235	406,218	4.5%
348,999,375	327,387,553	21,611,822	6.6%	Revenues	3,472,811,712	3,329,332,586	143,479,126	4.3%
308,989,504	307,082,756	(1,906,748)	(0.6%)	Medical Expenses	3,214,447,060	3,121,837,529	(92,609,531)	(3.0%)
15,675,690	18,766,126	3,090,436	16.5%	Administrative Expenses	151,833,358	180,917,657	29,084,299	16.1%
24,334,181	**1,538,671**	**22,795,510**	**1481.5%**	**Operating Margin**	**106,531,294**	**26,577,400**	**79,953,894**	**300.8%**
				Non-Operating Income (Loss)				
12,002,821	500,000	11,502,821	2300.6%	Net Investment Income/Expense	74,080,087	5,000,000	69,080,087	1381.6%
77,068	90,835	(13,767)	(15.2%)	Net Rental Income/Expense	837,999	908,350	(70,351)	(7.7%)
(2,917)	-	(2,917)	(100.0%)	Net MCO Tax	17,937	-	17,937	100.0%
(863,636)	(2,077,922)	1,214,286	58.4%	Grant Expense	(23,636,364)	(15,844,154)	(7,792,210)	(49.2%)
-	-	-	0.0%	Net QAF/IGT Income/Expense	-	-	-	0.0%
30	-	30	100.0%	Other Income/Expense	105	-	105	100.0%
11,213,366	**(1,487,087)**	**12,700,453**	**854.0%**	**Total Non-Operating Income (Loss)**	**51,299,764**	**(9,935,804)**	**61,235,568**	**616.3%**
35,547,547	**51,584**	**35,495,963**	**68812.0%**	**Change in Net Assets**	**157,831,058**	**16,641,596**	**141,189,462**	**848.4%**
88.5%	93.8%	(5.3%)		Medical Loss Ratio	92.6%	93.8%	(1.2%)	
4.5%	5.7%	1.2%		Administrative Loss Ratio	4.4%	5.4%	1.1%	
7.0%	0.5%	6.5%		Operating Margin Ratio	3.1%	0.8%	2.3%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
88.5%	93.8%	(5.3%)		*MLR (excluding Directed Payments)	91.9%	93.8%	(1.9%)	
4.5%	5.7%	1.2%		*ALR (excluding Directed Payments)	4.8%	5.4%	0.7%	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

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CalOptima Health
Financial Dashboard
For the Ten Months Ended April 30, 2023

April

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	967,146	887,454	79,692	9.0%
OneCare Connect	-	-	-	0.0%
OneCare	17,406	16,876	530	3.1%
PACE	434	496	(62)	(12.5%)
MSSP	473	568	(95)	(16.7%)
Total*	984,986	904,826	80,160	8.9%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 21,363	$ 114	21,249	18639.5%
OneCare Connect	(854)	(41)	(813)	(1982.9%)
OneCare	2,771	(738)	3,509	475.5%
PACE	274	165	109	66.1%
MSSP	(85)	(40)	(45)	(112.5%)
Buildings	77	91	(14)	(15.4%)
Investment Income/Expense	12,003	500	11,503	2300.6%
Total	$ 35,549	$ 51	35,498	69603.9%

MLR	Actual	Budget	% Point Var
Medi-Cal	88.7%	93.8%	(5.1)
OneCare Connect	69.3%	0.0%	69.3
OneCare	85.3%	94.3%	(9.0)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 13,420	$ 16,048	$ 2,628	16.4%
OneCare Connect	46	14	(32)	(227.6%)
OneCare	1,856	2,354	498	21.2%
PACE	256	256	0	0.1%
MSSP	97	94	(3)	(3.3%)
Total	$ 15,676	$ 18,766	$ 3,090	16.5%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,213	1,323	109
OneCare Connect	5	2	(3)
OneCare	182	222	40
PACE	101	115	14
MSSP	22	23	1
Total	1,523	1,684	161

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	797	671	(126)
OneCare Connect	-	-	-
OneCare	95	76	(19)
PACE	4	4	0
MSSP	21	25	4
Total	647	537	(109)

July to April

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	9,347,886	8,942,910	404,976	4.5%
OneCare Connect	86,185	87,887	(1,702)	(1.9%)
OneCare	87,045	83,721	3,324	4.0%
PACE	4,337	4,717	(380)	(8.1%)
MSSP	4,724	5,680	(956)	(16.8%)
Total*	9,525,453	9,119,235	406,218	4.5%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 84,743	$ 20,693	64,050	309.5%
OneCare Connect	(1,647)	(3,096)	1,449	46.8%
OneCare	(976)	(6,558)	5,582	85.1%
PACE	1,508	126	1,382	1096.8%
MSSP	(714)	(432)	(282)	(65.3%)
Buildings	838	908	(70)	(7.7%)
Investment Income/Expense	74,080	5,000	69,080	1381.6%
Total	$ 157,832	$ 16,641	141,191	848.5%

MLR	Actual	Budget	% Point Var
Medi-Cal	92.4%	93.6%	(1.2)
OneCare Connect	95.1%	95.2%	(0.1)
OneCare	93.8%	96.2%	(2.4)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 128,818	$ 154,542	$ 25,724	16.6%
OneCare Connect	10,069	11,153	1,085	9.7%
OneCare	9,947	11,608	1,661	14.3%
PACE	2,107	2,643	536	20.3%
MSSP	893	972	79	8.1%
Total	$ 151,833	$ 180,918	$ 29,084	16.1%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	11,707	13,146	1,439
OneCare Connect	1,027	1,189	162
OneCare	792	1,034	242
PACE	962	1,141	179
MSSP	207	230	23
Total	14,695	16,740	2,044

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	798	680	(118)
OneCare Connect	84	74	(10)
OneCare	110	81	(29)
PACE	5	4	(0)
MSSP	23	25	2
Total	648	545	(103)

Note:* Total membership does not include MSSP

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CalOptima Health - Consolidated
Statement of Revenues and Expenses
For the One Month Ended April 30, 2023

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	984,986		904,826		80,160	
REVENUE						
Medi-Cal	$ 316,343,845	$ 327.09	$ 294,713,757	$ 332.09	$ 21,630,088	$ (5)
OneCare Connect	(2,627,134)	-	-	-	(2,627,134)	-
OneCare	31,397,493	1,803.83	28,228,853	1,672.72	3,168,640	131.11
PACE	3,674,281	8,466.08	4,191,426	8,450.46	(517,145)	15.62
MSSP	210,891	445.86	253,517	446.33	(42,626)	(0.47)
Total Operating Revenue	348,999,375	354.32	327,387,553	361.82	21,611,822	(7.50)
MEDICAL EXPENSES						
Medi-Cal	280,694,332	290.23	276,473,585	311.54	(4,220,747)	21.31
OneCare Connect	(1,819,596)	-	27,242	-	1,846,838	-
OneCare	26,770,817	1,538.02	26,612,585	1,576.95	(158,232)	38.93
PACE	3,144,363	7,245.08	3,769,864	7,600.53	625,501	355.45
MSSP	199,588	421.96	199,480	351.20	(108)	(70.76)
Total Medical Expenses	308,989,504	313.70	307,082,756	339.38	(1,906,748)	25.68
GROSS MARGIN	40,009,871	40.62	20,304,797	22.44	19,705,074	18.18
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	10,419,426	10.58	10,941,211	12.09	521,785	1.51
Professional Fees	524,317	0.53	1,065,068	1.18	540,751	0.65
Purchased Services	1,244,792	1.26	2,745,167	3.03	1,500,375	1.77
Printing & Postage	461,169	0.47	691,677	0.76	230,508	0.29
Depreciation & Amortization	368,140	0.37	525,900	0.58	157,760	0.21
Other Expenses	2,284,098	2.32	2,401,779	2.65	117,681	0.33
Indirect Cost Allocation, Occupancy	373,748	0.38	395,324	0.44	21,576	0.06
Total Administrative Expenses	15,675,690	15.91	18,766,126	20.74	3,090,436	4.83
INCOME (LOSS) FROM OPERATIONS	24,334,181	24.71	1,538,671	1.70	22,795,510	23.01
INVESTMENT INCOME						
Interest Income	10,474,721	10.63	500,000	0.55	9,974,721	10.08
Realized Gain/(Loss) on Investments	(578,828)	(0.59)	-	-	(578,828)	(0.59)
Unrealized Gain/(Loss) on Investments	2,106,929	2.14	-	-	2,106,929	2.14
Total Investment Income	12,002,821	12.19	500,000	0.55	11,502,821	11.64
NET RENTAL INCOME	77,068	0.08	90,835	0.10	(13,767)	(0.02)
TOTAL MCO TAX	(2,917)	-	-	-	(2,917)	-
TOTAL GRANT EXPENSE	(863,636)	(0.88)	(2,077,922)	(2.30)	1,214,286	1.42
OTHER INCOME	30	-	-	-	30	-
CHANGE IN NET ASSETS	**35,547,547**	**36.09**	**51,584**	**0.06**	**35,495,963**	**36.03**
MEDICAL LOSS RATIO	**88.5%**		**93.8%**		**(5.3%)**	
ADMINISTRATIVE LOSS RATIO	**4.5%**		**5.7%**		**1.2%**	

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CalOptima Health- Consolidated
Statement of Revenues and Expenses
For the Ten Months Ended April 30, 2023

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	9,525,453		9,119,235		406,218	
REVENUE						
Medi-Cal	$ 3,116,479,525	$ 333.39	2,987,256,790	$ 334.04	$ 129,222,735	$ (0.65)
OneCare Connect	172,744,449	2,004.34	167,628,057	1,907.31	5,116,392	97.03
OneCare	145,272,589	1,668.94	132,560,256	1,583.36	12,712,333	85.58
PACE	36,302,135	8,370.33	39,352,313	8,342.66	(3,050,178)	27.67
MSSP	2,013,015	426.13	2,535,170	446.33	(522,155)	(20.20)
Total Operating Revenue	3,472,811,712	364.58	3,329,332,586	365.09	143,479,126	(0.51)
MEDICAL EXPENSES						
Medi-Cal	2,879,300,529	308.02	2,796,177,710	312.67	(83,122,819)	4.65
OneCare Connect	164,322,948	1,906.63	159,571,190	1,815.64	(4,751,758)	(90.99)
OneCare	136,301,499	1,565.87	127,510,982	1,523.05	(8,790,517)	(42.82)
PACE	32,687,613	7,536.92	36,582,847	7,755.53	3,895,234	218.61
MSSP	1,834,471	388.33	1,994,800	351.20	160,329	(37.13)
Total Medical Expenses	3,214,447,060	337.46	3,121,837,529	342.34	(92,609,531)	4.88
GROSS MARGIN	258,364,652	27.12	207,495,057	22.75	50,869,595	4.37
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	103,239,319	10.84	112,989,799	12.39	9,750,480	1.55
Professional Fees	6,365,317	0.67	9,693,813	1.06	3,328,496	0.39
Purchased Services	11,539,213	1.21	18,079,424	1.98	6,540,211	0.77
Printing & Postage	4,471,356	0.47	5,808,227	0.64	1,336,871	0.17
Depreciation & Amortization	3,709,508	0.39	5,259,000	0.58	1,549,492	0.19
Other Expenses	18,817,002	1.98	24,338,388	2.67	5,521,386	0.69
Indirect Cost Allocation, Occupancy	3,691,644	0.39	4,749,006	0.52	1,057,362	0.13
Total Administrative Expenses	151,833,358	15.94	180,917,657	19.84	29,084,299	3.90
INCOME (LOSS) FROM OPERATIONS	106,531,294	11.18	26,577,400	2.91	79,953,894	8.27
INVESTMENT INCOME						
Interest Income	72,205,339	7.58	5,000,000	0.55	67,205,339	7.03
Realized Gain/(Loss) on Investments	(8,282,856)	(0.87)	-	0.00	(8,282,856)	(0.87)
Unrealized Gain/(Loss) on Investments	10,157,603	1.07	-	0.00	10,157,603	1.07
Total Investment Income	74,080,087	7.78	5,000,000	0.55	69,080,087	7.23
NET RENTAL INCOME	837,999	0.09	908,350	0.10	(70,351)	(0.01)
TOTAL MCO TAX	17,937	0.00	-	0.00	17,937	0.00
TOTAL GRANT EXPENSE	(23,636,364)	(2.48)	(15,844,154)	(1.74)	(7,792,210)	(0.74)
OTHER INCOME	105	0.00	-	0.00	105	0.00
CHANGE IN NET ASSETS	**157,831,058**	**16.57**	**16,641,596**	**1.82**	**141,189,462**	**14.75**
MEDICAL LOSS RATIO	**92.6%**		**93.8%**		**(1.2%)**	
ADMINISTRATIVE LOSS RATIO	**4.4%**		**5.4%**		**1.1%**	

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CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended April 30, 2023

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	592,965	362,563	11,618	967,146		17,406	434	473	984,986
REVENUES									
Capitation Revenue	190,496,357	$ 106,568,974	$ 19,278,515	$ 316,343,845	$ (2,627,134)	$ 31,397,493	$ 3,674,281	$ 210,891	$ 348,999,375
Total Operating Revenue	190,496,357	106,568,974	19,278,515	316,343,845	(2,627,134)	31,397,493	3,674,281	210,891	348,999,375
MEDICAL EXPENSES									
Provider Capitation	46,696,211	52,911,614	7,066,987	106,674,812	22	12,590,206			119,265,040
Facilities	26,687,108	25,141,412	6,961,283	58,789,803	3,994	4,857,895	642,137		64,293,829
Professional Claims	27,186,587	17,015,891	2,042,394	46,244,872	20,225	1,252,081	1,022,276		48,539,453
Prescription Drugs	(962,465)			(962,465)	(1,630,439)	6,554,807	413,076		4,374,978
MLTSS	38,463,650	4,771,263	960,806	44,195,718	(186,040)	80,601	33,233	31,160	44,154,671
Incentive Payments	11,135,495	8,114,130	217,682	19,467,307	(51,238)	271,433			19,687,502
Medical Management	2,982,274	1,446,831	387,855	4,816,960	23,881	1,163,793	1,033,643	168,428	7,206,705
Other Medical Expenses	907,664	541,488	18,175	1,467,326					1,467,326
Total Medical Expenses	153,096,523	109,942,628	17,655,180	280,694,332	(1,819,596)	26,770,817	3,144,363	199,588	308,989,504
Medical Loss Ratio	80.4%	103.2%	91.6%	88.7%	69.3%	85.3%	85.6%	94.6%	88.5%
GROSS MARGIN	**37,399,833**	**(3,373,655)**	**1,623,335**	**35,649,513**	**(807,538)**	**4,626,676**	**529,918**	**11,303**	**40,009,871**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				9,392,654	25,351	779,856	139,787	81,777	10,419,426
Professional Fees				487,558	13,238	20,833	1,354	1,333	524,317
Purchased Services				1,032,424	(3,039)	141,431	73,971	5	1,244,792
Printing & Postage				422,512	9,376	24,063	5,217		461,169
Depreciation & Amortization				367,043			1,097		368,140
Other Expenses				2,248,828	1,416	5,033	20,812	8,009	2,284,098
Indirect Cost Allocation, Occupancy				(530,587)		884,890	13,932	5,513	373,748
Total Administrative Expenses				**13,420,433**	**46,342**	**1,856,107**	**256,170**	**96,638**	**15,675,690**
Admin Loss Ratio				4.2%	-1.8%	5.9%	7.0%	45.8%	4.5%
INCOME (LOSS) FROM OPERATIONS				22,229,080	(853,881)	2,770,569	273,747	(85,335)	24,334,181
INVESTMENT INCOME									12,002,821
NET RENTAL INCOME									77,068
TOTAL MCO TAX				(2,917)					(2,917)
TOTAL GRANT EXPENSE				(863,636)					(863,636)
OTHER INCOME				30					30
CHANGE IN NET ASSETS				**$ 21,362,557**	**$ (853,881)**	**$ 2,770,569**	**$ 273,747**	**$ (85,335)**	**$ 35,547,547**
BUDGETED CHANGE IN NET ASSETS				114,238	(41,387)	(737,750)	165,162	(39,514)	51,584
VARIANCE TO BUDGET - FAV (UNFAV)				$ 21,248,319	$ (812,494)	$ 3,508,319	$ 108,585	$ (45,821)	$ 35,495,963

Note:* Total membership does not include MSSP

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CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Ten Months Ended April 30, 2023

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	5,757,472	3,472,386	118,028	9,347,886	86,185	87,045	4,337	4,724	9,525,453
REVENUES									
Capitation Revenue	1,622,367,871	$ 1,265,374,329	$ 228,737,325	$ 3,116,479,525	$ 172,744,449	$ 145,272,589	$ 36,302,135	$ 2,013,015	$ 3,472,811,712
Total Operating Revenue	1,622,367,871	1,265,374,329	228,737,325	3,116,479,525	172,744,449	145,272,589	36,302,135	2,013,015	3,472,811,712
MEDICAL EXPENSES									
Provider Capitation	388,896,982	469,263,782	83,411,379	941,572,143	72,095,156	56,723,537			1,070,390,836
Facilities	321,455,605	282,802,151	53,694,604	657,952,359	26,987,617	26,018,312	7,778,136		718,736,424
Professional Claims	238,025,710	146,497,963	15,140,821	399,664,494	8,736,375	6,278,868	9,549,657		424,229,394
Prescription Drugs	(3,220,624)	(2,287,072)	5,604	(5,502,092)	37,735,773	41,605,659	4,138,078		77,977,419
MLTSS	384,773,043	44,681,013	18,664,555	448,118,611	9,603,761	321,073	1,396,440	288,845	459,728,729
Incentive Payments	38,970,587	39,839,182	1,020,947	79,830,716	2,345,716	725,217	(120,875)		82,780,775
Medical Management	28,678,135	19,501,190	4,260,737	52,440,062	6,818,551	4,628,833	9,946,177	1,545,626	75,379,248
Other Medical Expenses	162,588,902	124,039,715	18,595,618	305,224,234					305,224,234
Total Medical Expenses	1,560,168,340	1,124,337,924	194,794,265	2,879,300,529	164,322,948	136,301,499	32,687,613	1,834,471	3,214,447,060
Medical Loss Ratio	96.2%	88.9%	85.2%	92.4%	95.1%	93.8%	90.0%	91.1%	92.6%
GROSS MARGIN	**62,199,531**	**141,036,405**	**33,943,060**	**237,178,996**	**8,421,500**	**8,971,090**	**3,614,523**	**178,544**	**258,364,652**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				92,815,995	4,247,381	4,046,505	1,366,667	762,771	103,239,319
Professional Fees				6,072,348	24,884	250,291	4,461	13,333	6,365,317
Purchased Services				9,749,525	594,498	903,690	291,494	5	11,539,213
Printing & Postage				3,211,293	261,432	810,109	188,522		4,471,356
Depreciation & Amortization				3,701,287			8,222		3,709,508
Other Expenses				18,619,100	10,498	17,390	108,233	61,782	18,817,002
Indirect Cost Allocation, Occupancy				(5,351,707)	4,929,832	3,919,071	139,316	55,132	3,691,644
Total Administrative Expenses				**128,817,840**	**10,068,525**	**9,947,055**	**2,106,916**	**893,023**	**151,833,358**
Admin Loss Ratio				4.1%	5.8%	6.8%	5.8%	44.4%	4.4%
INCOME (LOSS) FROM OPERATIONS				108,361,156	(1,647,025)	(975,965)	1,507,607	(714,479)	106,531,294
INVESTMENT INCOME									74,080,087
NET RENTAL INCOME									837,999
TOTAL MCO TAX				17,937					17,937
TOTAL GRANT EXPENSE				(23,636,364)					(23,636,364)
OTHER INCOME				105					105
CHANGE IN NET ASSETS				**$ 84,742,834**	**$ (1,647,025)**	**$ (975,965)**	**$ 1,507,607**	**$ (714,479)**	**$ 157,831,058**
BUDGETED CHANGE IN NET ASSETS				20,693,339	(3,096,310)	(6,558,387)	126,215	(431,611)	16,641,596
VARIANCE TO BUDGET - FAV (UNFAV)				$ 64,049,495	$ 1,449,285	$ 5,582,422	$ 1,381,392	$ (282,868)	$ 141,189,462

Note:* Total membership does not include MSSP

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CalOptima Health

April 30, 2023 Unaudited Financial Statements

MONTHLY RESULTS:

- Change in Net Assets is $35.5 million, $35.5 million favorable to budget
- Operating surplus is $24.3 million, with a surplus in non-operating income of $11.2 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $157.8 million, $141.2 million favorable to budget
- Operating surplus is $106.5 million, with a surplus in non-operating income of $51.3 million

Change in Net Assets by Line of Business (LOB) ($ millions):

March				July-March		
Actual	Budget	Variance	**Operating Income (Loss)**	Actual	Budget	Variance
22.2	2.2	20.0	Medi-Cal	108.4	36.5	71.8
(0.9)	(0.0)	(0.8)	OCC	(1.6)	(3.1)	1.4
2.8	(0.7)	3.5	OneCare	(1.0)	(6.6)	5.6
0.3	0.2	0.1	PACE	1.5	0.1	1.4
(0.1)	(0.0)	(0.0)	MSSP	(0.7)	(0.4)	(0.3)
24.3	**1.5**	**22.8**	**Total Operating Income (Loss)**	**106.5**	**26.6**	**80.0**
			Non-Operating Income (Loss)			
12.0	0.5	11.5	Net Investment Income/Expense	74.1	5.0	69.1
0.1	0.1	(0.0)	Net Rental Income/Expense	0.8	0.9	(0.1)
(0.0)	0.0	(0.0)	Net Operating Tax	0.0	0.0	0.0
(0.9)	(2.1)	1.2	Grant Expense	(23.6)	(15.8)	(7.8)
0.0	0.0	0.0	Other Income	0.0	0.0	0.0
11.2	**(1.5)**	**12.7**	**Total Non-Operating Income/(Loss)**	**51.3**	**(9.9)**	**61.2**
35.5	**0.1**	**35.5**	**TOTAL**	**157.8**	**16.6**	**141.2**

CalOptima Health - Consolidated
Enrollment Summary
For the Ten Months Ended April 30, 2023

April					July to April			
		$	%				$	%
Actual	Budget	Variance	Variance	Enrollment (by Aid Category)	Actual	Budget	Variance	Variance
141,452	138,812	2,640	1.9%	SPD	1,313,420	1,289,686	23,734	1.8%
306,307	302,660	3,647	1.2%	TANF Child	3,042,851	3,051,147	(8,296)	(0.3%)
141,973	127,389	14,584	11.4%	TANF Adult	1,369,017	1,325,792	43,225	3.3%
3,233	3,501	(268)	(7.7%)	LTC	32,184	33,962	(1,778)	(5.2%)
362,563	303,220	59,343	19.6%	MCE	3,472,386	3,124,375	348,011	11.1%
11,618	11,872	(254)	(2.1%)	WCM	118,028	117,948	80	0.1%
967,146	**887,454**	**79,692**	**9.0%**	**Medi-Cal Total**	**9,347,886**	**8,942,910**	**404,976**	**4.5%**
		0	**0.0%**	**OneCare Connect**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
17,406	**16,876**	**530**	**3.1%**	**OneCare**	**87,045**	**83,721**	**3,324**	**4.0%**
434	**496**	**(62)**	**(12.5%)**	**PACE**	**4,337**	**4,717**	**(380)**	**(8.1%)**
473	**568**	**(95)**	**(16.7%)**	**MSSP**	**4,724**	**5,680**	**(956)**	**(16.8%)**
984,986	**904,826**	**80,160**	**8.9%**	**CalOptima Health Total**	**9,525,453**	**9,119,235**	**406,218**	**4.5%**
				Enrollment (by Network)				
270,248	203,875	66,373	32.6%	HMO	2,443,204	2,087,268	355,936	17.1%
193,522	234,295	(40,773)	(17.4%)	PHC	2,102,440	2,375,327	(272,887)	(11.5%)
235,834	215,351	20,483	9.5%	Shared Risk Group	2,294,647	2,198,606	96,041	4.4%
267,542	233,933	33,609	14.4%	Fee for Service	2,507,595	2,281,709	225,886	9.9%
967,146	**887,454**	**79,692**	**9.0%**	**Medi-Cal Total**	**9,347,886**	**8,942,910**	**404,976**	**4.5%**
0	**0**	**0**	**0.0%**	**OneCare Connect**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
17,406	**16,876**	**530**	**3.1%**	**OneCare**	**87,045**	**83,721**	**3,324**	**4.0%**
434	**496**	**(62)**	**(12.5%)**	**PACE**	**4,337**	**4,717**	**(380)**	**(8.1%)**
473	**568**	**(95)**	**(16.7%)**	**MSSP**	**4,724**	**5,680**	**(956)**	**(16.8%)**
984,986	**904,826**	**80,160**	**8.9%**	**CalOptima Health Total**	**9,525,453**	**9,119,235**	**406,218**	**4.5%**

Note:* Total membership does not include MSSP

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2023

	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	YTD Actual	YTD Budget	Variance
HMOs															
SPD	11,237	11,250	11,290	11,288	14,002	14,044	14,044	14,090	14,108	14,091			129,444	109,916	19,528
TANF Child	58,966	58,892	58,837	58,847	69,892	69,736	69,972	70,036	70,162	70,142			655,482	590,296	65,186
TANF Adult	38,926	38,983	39,331	39,640	48,530	48,844	49,255	49,567	49,999	50,561			453,636	410,930	42,706
LTC	1	2	2	1				1		3			10		10
MCE	99,022	99,788	100,301	101,292	127,939	128,438	129,823	131,179	131,973	133,319			1,183,074	954,902	228,172
WCM	2,034	2,020	2,021	2,050	2,272	2,268	2,242	2,285	2,234	2,132			21,558	21,224	334
Total	**210,186**	**210,935**	**211,782**	**213,118**	**262,635**	**263,330**	**265,336**	**267,158**	**268,476**	**270,248**			**2,443,204**	**2,087,268**	**355,936**
PHCs															
SPD	7,040	7,022	7,037	7,029	4,408	4,387	4,435	4,356	4,476	4,436			54,626	69,953	(15,327)
TANF Child	158,385	158,345	158,767	159,067	148,298	148,419	148,820	149,257	149,182	149,847			1,528,387	1,591,197	(62,810)
TANF Adult	16,704	16,780	16,830	16,855	8,478	8,499	8,550	8,590	8,640	8,718			118,644	172,495	(53,851)
LTC		1	1	3		2							7		7
MCE	47,505	47,574	47,748	48,051	22,411	22,545	22,920	23,161	23,297	23,504			328,716	468,988	(140,272)
WCM	7,366	7,472	7,340	7,301	7,096	7,142	7,175	7,108	7,043	7,017			72,060	72,694	(634)
Total	**237,000**	**237,194**	**237,723**	**238,306**	**190,691**	**190,994**	**191,900**	**192,472**	**192,638**	**193,522**			**2,102,440**	**2,375,327**	**(272,887)**
Shared Risk Groups															
SPD	10,824	10,928	10,995	10,954	11,023	11,046	11,181	11,053	11,123	11,105			110,232	101,930	8,302
TANF Child	57,419	57,075	56,762	56,460	56,201	55,828	55,913	55,869	55,922	55,824			563,273	598,639	(35,366)
TANF Adult	40,518	40,260	40,370	40,566	40,961	41,218	41,636	42,055	42,377	43,108			413,069	401,309	11,760
LTC	2	1	3	6	2				1	1			16		16
MCE	114,819	115,585	116,539	117,839	118,935	119,808	121,272	122,217	123,296	124,524			1,194,834	1,082,791	112,043
WCM	1,360	1,341	1,332	1,369	1,325	1,303	1,294	1,317	1,310	1,272			13,223	13,937	(714)
Total	**224,942**	**225,190**	**226,001**	**227,194**	**228,447**	**229,203**	**231,296**	**232,511**	**234,029**	**235,834**			**2,294,647**	**2,198,606**	**96,041**
Fee for Service (Dual)															
SPD	82,253	82,742	82,935	83,572	84,174	83,819	98,278	98,465	98,630	98,988			893,856	894,203	(347)
TANF Child	1	1	1	1	1	1	1	1	1	1			10		10
TANF Adult	1,675	1,712	1,743	1,742	1,767	1,776	2,271	2,318	2,310	2,360			19,674	19,847	(173)
LTC	2,894	2,874	2,845	2,879	2,929	2,915	2,943	2,745	2,683	2,870			28,577	30,612	(2,035)
MCE	6,480	6,749	7,030	7,314	7,498	7,795	8,014	8,269	8,589	8,853			76,591	54,484	22,107
WCM	20	18	24	17	16	18	14	16	16	16			175	153	22
Total	**93,323**	**94,096**	**94,578**	**95,525**	**96,385**	**96,324**	**111,521**	**111,814**	**112,229**	**113,088**			**1,018,883**	**999,299**	**19,584**
Fee for Service (Non-Dual - Total)															
SPD	11,984	12,003	16,296	8,528	12,224	12,480	15,537	10,292	13,086	12,832			125,262	113,684	11,578
TANF Child	28,613	28,702	29,350	29,540	30,022	28,970	30,017	30,313	29,679	30,493			295,699	271,015	24,684
TANF Adult	32,830	33,442	37,388	38,818	35,106	35,368	37,021	39,824	36,971	37,226			363,994	321,211	42,783
LTC	360	364	366	345	344	346	367	366	357	359			3,574	3,350	224
MCE	63,450	64,657	66,876	67,538	69,063	69,002	71,735	72,881	71,606	72,363			689,171	563,210	125,961
WCM	1,096	1,094	1,049	1,080	1,036	1,069	1,094	1,147	1,166	1,181			11,012	9,940	1,072
Total	**138,333**	**140,262**	**151,325**	**145,849**	**147,795**	**147,235**	**155,771**	**154,823**	**152,865**	**154,454**			**1,488,712**	**1,282,410**	**206,302**
Grand Totals															
SPD	123,338	123,945	128,553	121,371	125,831	125,776	143,475	138,256	141,423	141,452			1,313,420	1,289,686	23,734
TANF Child	303,384	303,015	303,717	303,915	304,414	302,954	304,723	305,476	304,946	306,307			3,042,851	3,051,147	(8,296)
TANF Adult	130,653	131,177	135,662	137,621	134,842	135,705	138,733	142,354	140,297	141,973			1,369,017	1,325,792	43,225
LTC	3,257	3,242	3,217	3,234	3,275	3,263	3,310	3,112	3,041	3,233			32,184	33,962	(1,778)
MCE	331,276	334,353	338,494	342,034	345,846	347,588	353,764	357,707	358,761	362,563			3,472,386	3,124,375	348,011
WCM	11,876	11,945	11,766	11,817	11,745	11,800	11,819	11,873	11,769	11,618			118,028	117,948	80
Total MediCal MM	**903,784**	**907,677**	**921,409**	**919,992**	**925,953**	**927,086**	**955,824**	**958,778**	**960,237**	**967,146**			**9,347,886**	**8,942,910**	**404,976**
OneCare Connect	**14,203**	**14,771**	**14,405**	**14,198**	**14,197**	**14,385**	**26**						**86,185**	**87,887**	**(1,702)**
OneCare	**2,764**	**2,874**	**2,905**	**2,964**	**3,015**	**3,067**	**17,293**	**17,342**	**17,415**	**17,406**			**87,045**	**83,721**	**3,324**
PACE	**435**	**434**	**437**	**430**	**433**	**437**	**428**	**432**	**437**	**434**			**4,337**	**4,717**	**(380)**
MSSP	**466**	**470**	**478**	**478**	**476**	**471**	**467**	**472**	**473**	**473**			**4,724**	**5,680**	**(956)**
Grand Total	**921,186**	**925,756**	**939,156**	**937,584**	**943,598**	**944,975**	**973,571**	**976,552**	**978,089**	**984,986**			**9,525,453**	**9,119,235**	**406,218**

Note:* Total membership does not include MSSP

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ENROLLMENT:

Overall, April enrollment was 984,986

- Favorable to budget 80,160 or 8.9%
- Increased 6,897 or 0.7% from Prior Month (PM) (March 2023)
- Increased 93,376 or 10.5% from Prior Year (PY) (April 2022)

Medi-Cal enrollment was 967,146

- Favorable to budget 79,692 or 9.0% driven by Department of Health Care Services (DHCS) pause of Medi-Cal redetermination due to the extension of the Public Health Emergency (PHE), which expired on May 11, 2023
  - Medi-Cal Expansion (MCE) favorable 59,343
  - Temporary Assistance for Needy Families (TANF) favorable 18,231
  - Seniors and Persons with Disabilities (SPD) favorable 2,640
  - Long-Term Care (LTC) unfavorable 268
  - Whole Child Model (WCM) unfavorable 254
- Increased 6,909 from PM

OneCare enrollment was 17,406

- Favorable to budget 530 or 3.1%
- Decreased 9 from PM

PACE enrollment was 434

- Unfavorable to budget 62 or 12.5%
- Decreased 3 from PM

MSSP enrollment was 473

- Unfavorable to budget 95 or 16.7% driven by limitation on enrollment due to MSSP staff ratio. Program is fully staffed as of April 2023
- No change from PM

OneCare Connect enrollment was 0 due to transition of OCC members to OC, effective January 1, 2023

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Ten Months Ending April 30, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
967,146	**887,454**	**79,692**	**9.0%**	**Member Months**	**9,347,886**	**8,942,910**	**404,976**	**4.5%**
				Revenues				
316,343,845	294,713,757	21,630,088	7.3%	Medi-Cal Capitation Revenue	3,116,479,525	2,987,256,790	129,222,735	4.3%
316,343,845	**294,713,757**	**21,630,088**	**7.3%**	**Total Operating Revenue**	**3,116,479,525**	**2,987,256,790**	**129,222,735**	**4.3%**
				Medical Expenses				
106,674,812	103,318,835	(3,355,977)	(3.2%)	Provider Capitation	941,572,143	1,054,171,155	112,599,012	10.7%
58,789,803	67,297,715	8,507,912	12.6%	Facilities Claims	657,952,359	677,648,632	19,696,273	2.9%
46,244,872	41,106,864	(5,138,008)	(12.5%)	Professional Claims	399,664,494	406,364,616	6,700,122	1.6%
44,195,718	52,274,343	8,078,625	15.5%	MLTSS	448,118,611	506,261,047	58,142,436	11.5%
(962,465)	-	962,465	100.0%	Prescription Drugs	(5,502,092)	-	5,502,092	100.0%
19,467,307	4,596,029	(14,871,278)	(323.6%)	Incentive Payments	79,830,716	46,559,920	(33,270,796)	(71.5%)
4,816,960	6,305,727	1,488,767	23.6%	Medical Management	52,440,062	66,931,621	14,491,559	21.7%
1,467,326	1,574,072	106,746	6.8%	Other Medical Expenses	305,224,234	38,240,719	(266,983,515)	(698.2%)
280,694,332	**276,473,585**	**(4,220,747)**	**(1.5%)**	**Total Medical Expenses**	**2,879,300,529**	**2,796,177,710**	**(83,122,819)**	**(3.0%)**
35,649,513	**18,240,172**	**17,409,341**	**95.4%**	**Gross Margin**	**237,178,996**	**191,079,080**	**46,099,916**	**24.1%**
				Administrative Expenses				
9,392,654	9,691,253	298,599	3.1%	Salaries, Wages & Employee Benefits	92,815,995	99,833,241	7,017,246	7.0%
487,558	1,012,739	525,181	51.9%	Professional Fees	6,072,348	9,217,530	3,145,182	34.1%
1,032,424	2,284,013	1,251,589	54.8%	Purchased Services	9,749,525	15,204,486	5,454,961	35.9%
422,512	487,740	65,228	13.4%	Printing & Postage	3,211,293	4,230,434	1,019,141	24.1%
367,043	525,000	157,957	30.1%	Depreciation & Amortization	3,701,287	5,250,000	1,548,713	29.5%
2,248,828	2,372,927	124,099	5.2%	Other Operating Expenses	18,619,100	24,062,496	5,443,396	22.6%
(530,587)	(325,660)	204,927	62.9%	Indirect Cost Allocation, Occupancy	(5,351,707)	(3,256,600)	2,095,107	64.3%
13,420,433	**16,048,012**	**2,627,579**	**16.4%**	**Total Administrative Expenses**	**128,817,840**	**154,541,587**	**25,723,747**	**16.6%**
				Non-Operating Income (Loss)				
(2,917)	-	(2,917)	(100.0%)	Net Operating Tax	17,937	-	17,937	100.0%
(863,636)	(2,077,922)	1,214,286	58.4%	Grant Expense	(23,636,364)	(15,844,154)	(7,792,210)	(49.2%)
30	-	30	100.0%	Other Income	105	-	105	100.0%
(866,523)	**(2,077,922)**	**1,211,399**	**58.3%**	**Total Non-Operating Income (Loss)**	**(23,618,322)**	**(15,844,154)**	**(7,774,168)**	**(49.1%)**
21,362,557	**114,238**	**21,248,319**	**18600.0%**	**Change in Net Assets**	**84,742,834**	**20,693,339**	**64,049,495**	**309.5%**
88.7%	***93.8%***	***(5.1%)***		***Medical Loss Ratio***	***92.4%***	***93.6%***	***(1.2%)***	
4.2%	***5.4%***	***1.2%***		***Admin Loss Ratio***	***4.1%***	***5.2%***	***1.0%***	

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MEDI-CAL INCOME STATEMENT– APRIL MONTH:

REVENUES of $316.3 million are favorable to budget $21.6 million driven by:

- Favorable volume related variance of $26.5 million
- Unfavorable price related variance of $4.8 million
    - $142.1 million due to updates to the COVID-19 risk corridor calculation
    - $4.5 million due to Enhanced Care Management (ECM) and Proposition 56 risk corridor reserves
    - Offset by:
        - $135.4 million from the release of the Adult Expansion Medical Loss Ratio (MLR) accruals for the period of January 1, 2014 through June 30, 2017 due to new information received from DHCS
        - $5.3 million from favorable Calendar Year (CY) 2023 premium capitation rates

MEDICAL EXPENSES of $280.7 million are unfavorable to budget $4.2 million driven by:

- Unfavorable volume related variance of $24.8 million
- Favorable price related variance of $20.6 million
    - Facilities Claims expense favorable variance of $14.6 million due to low utilization.
    - Managed Long-Term Services and Supports (MLTSS) favorable variance of $12.8 million due to lower than budgeted utilization
    - Provider Capitation expense favorable variance of $5.9 million
    - Medical Management expenses favorable variance of $2.1 million
    - Offset by:
        - Incentive Payments expense unfavorable variance of $14.9 million due primarily to Housing and Homelessness Incentive Program (HHIP)

ADMINISTRATIVE EXPENSES of $13.4 million are favorable to budget $2.6 million driven by:

- Other Non-Salary expense favorable to budget $2.3 million
- Salaries & Benefit expense favorable to budget $0.3 million

CHANGE IN NET ASSETS is $21.4 million, favorable to budget $21.2 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Ten Months Ending April 30, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
17,406	**16,876**	**530**	**3.1%**	**Member Months**	**87,045**	**83,721**	**3,324**	**4.0%**
				Revenues				
22,588,532	21,365,080	1,223,452	5.7%	Medicare Part C Revenue	105,315,204	98,658,281	6,656,923	6.7%
8,808,961	6,863,773	1,945,188	28.3%	Medicare Part D Revenue	39,957,385	33,901,975	6,055,410	17.9%
31,397,493	**28,228,853**	**3,168,640**	**11.2%**	**Total Operating Revenue**	**145,272,589**	**132,560,256**	**12,712,333**	**9.6%**
				Medical Expenses				
12,590,206	10,946,057	(1,644,149)	(15.0%)	Provider Capitation	56,723,537	48,696,522	(8,027,015)	(16.5%)
4,857,895	4,648,225	(209,670)	(4.5%)	Inpatient	26,018,312	26,033,532	15,220	0.1%
1,252,081	1,113,982	(138,099)	(12.4%)	Ancillary	6,278,868	5,026,125	(1,252,743)	(24.9%)
80,601	71,044	(9,557)	(13.5%)	MLTSS	321,073	285,404	(35,669)	(12.5%)
6,554,807	7,841,514	1,286,707	16.4%	Prescription Drugs	41,605,659	38,304,982	(3,300,677)	(8.6%)
271,433	663,907	392,474	59.1%	Incentive Payments	725,217	2,888,018	2,162,801	74.9%
1,163,793	1,327,856	164,063	12.4%	Medical Management	4,628,833	6,276,399	1,647,566	26.3%
26,770,817	**26,612,585**	**(158,232)**	**(0.6%)**	**Total Medical Expenses**	**136,301,499**	**127,510,982**	**(8,790,517)**	**(6.9%)**
4,626,676	**1,616,268**	**3,010,408**	**186.3%**	**Gross Margin**	**8,971,090**	**5,049,274**	**3,921,816**	**77.7%**
				Administrative Expenses				
779,856	991,483	211,627	21.3%	Salaries, Wages & Employee Benefits	4,046,505	4,997,383	950,878	19.0%
20,833	40,583	19,750	48.7%	Professional Fees	250,291	303,830	53,539	17.6%
141,431	392,542	251,111	64.0%	Purchased Services	903,690	1,700,576	796,886	46.9%
24,063	203,268	179,205	88.2%	Printing & Postage	810,109	1,044,924	234,815	22.5%
5,033	24,992	19,959	79.9%	Other Operating Expenses	17,390	82,468	65,078	78.9%
884,890	701,150	(183,740)	(26.2%)	Indirect Cost Allocation, Occupancy	3,919,071	3,478,480	(440,591)	(12.7%)
1,856,107	**2,354,018**	**497,911**	**21.2%**	**Total Administrative Expenses**	**9,947,055**	**11,607,661**	**1,660,606**	**14.3%**
2,770,569	**(737,750)**	**3,508,319**	**475.5%**	**Change in Net Assets**	**(975,965)**	**(6,558,387)**	**5,582,422**	**85.1%**
85.3%	***94.3%***	***(9.0%)***		***Medical Loss Ratio***	***93.8%***	***96.2%***	***(2.4%)***	
5.9%	***8.3%***	***2.4%***		***Admin Loss Ratio***	***6.8%***	***8.8%***	***1.9%***	

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ONECARE INCOME STATEMENT– APRIL MONTH:

REVENUES of $31.4 million are favorable to budget $3.2 million driven by:

- Favorable volume related variance of $0.9 million
- Favorable price related variance of $2.3 million

MEDICAL EXPENSES of $26.8 million are unfavorable to budget $0.2 million driven by:

- Unfavorable volume related variance of $0.8 million
- Favorable price related variance of $0.7 million
  - Prescription Drugs expense favorable variance of $1.5 million
  - Incentive Payments expense favorable variance of $0.4 million
  - Medical Management expense favorable variance of $0.2 million
  - Offset by:
    - Provider Capitation expense unfavorable variance of $1.3 million
    - All other expenses net unfavorable variance of $0.2 million

ADMINISTRATIVE EXPENSES of $1.9 million are favorable to budget $0.5 million driven by:

- Other Non-Salary expense favorable to budget $0.3 million
- Salaries & Benefit expense favorable to budget $0.2 million

CHANGE IN NET ASSETS is $2.8 million, favorable to budget $3.5 million

CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Ten Months Ending April 30, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
-	-	-	0.0%	**Member Months**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
				Revenues				
(114,493)	-	(114,493)	(100.0%)	Medi-Cal Revenue	16,151,129	16,971,109	(819,980)	(4.8%)
-	-	-	0.0%	Medicare Part C Revenue	121,331,695	117,560,580	3,771,115	3.2%
(2,512,641)	-	(2,512,641)	(100.0%)	Medicare Part D Revenue	35,261,624	33,096,368	2,165,256	6.5%
(2,627,134)	**-**	**(2,627,134)**	**(100.0%)**	**Total Operating Revenue**	**172,744,449**	**167,628,057**	**5,116,392**	**3.1%**
				Medical Expenses				
22	-	(22)	(100.0%)	Provider Capitation	72,095,156	69,401,413	(2,693,743)	(3.9%)
3,994	-	(3,994)	(100.0%)	Facilities Claims	26,987,617	24,684,406	(2,303,211)	(9.3%)
20,225	-	(20,225)	(100.0%)	Ancillary	8,736,375	7,214,705	(1,521,670)	(21.1%)
(186,040)	-	186,040	100.0%	MLTSS	9,603,761	8,924,314	(679,447)	(7.6%)
(1,630,439)	-	1,630,439	100.0%	Prescription Drugs	37,735,773	38,194,494	458,721	1.2%
(51,238)	-	51,238	100.0%	Incentive Payments	2,345,716	3,304,554	958,838	29.0%
23,881	27,242	3,361	12.3%	Medical Management	6,818,551	7,847,304	1,028,753	13.1%
(1,819,596)	**27,242**	**1,846,838**	**6779.4%**	**Total Medical Expenses**	**164,322,948**	**159,571,190**	**(4,751,758)**	**(3.0%)**
(807,538)	**(27,242)**	**(780,296)**	**(2864.3%)**	**Gross Margin**	**8,421,500**	**8,056,867**	**364,633**	**4.5%**
				Administrative Expenses				
25,351	14,145	(11,206)	(79.2%)	Salaries, Wages & Employee Benefits	4,247,381	5,595,792	1,348,411	24.1%
13,238	-	(13,238)	(100.0%)	Professional Fees	24,884	124,998	100,114	80.1%
(3,039)	9,666	12,705	131.4%	Purchased Services	594,498	722,299	127,801	17.7%
9,376	(9,666)	(19,042)	(197.0%)	Printing & Postage	261,432	340,427	78,995	23.2%
1,416	-	(1,416)	(100.0%)	Other Operating Expenses	10,498	36,561	26,063	71.3%
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	4,929,832	4,333,100	(596,732)	(13.8%)
46,342	**14,145**	**(32,197)**	**(227.6%)**	**Total Administrative Expenses**	**10,068,525**	**11,153,177**	**1,084,652**	**9.7%**
(853,881)	**(41,387)**	**(812,494)**	**(1963.2%)**	**Change in Net Assets**	**(1,647,025)**	**(3,096,310)**	**1,449,285**	**46.8%**
69.3%	***0.0%***	***69.3%***		***Medical Loss Ratio***	***95.1%***	***95.2%***	***(0.1%)***	
(1.8%)	***0.0%***	***1.8%***		***Admin Loss Ratio***	***5.8%***	***6.7%***	***0.8%***	

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CalOptima Health
PACE
Statement of Revenues and Expenses
For the Ten Months Ending April 30, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
434	**496**	(62)	(12.5%)	**Member Months**	**4,337**	**4,717**	**(380)**	**(8.1%)**
				Revenues				
2,818,828	3,192,453	(373,625)	(11.7%)	Medi-Cal Capitation Revenue	27,964,911	30,117,798	(2,152,887)	(7.1%)
616,175	787,310	(171,135)	(21.7%)	Medicare Part C Revenue	6,234,848	7,226,416	(991,568)	(13.7%)
239,278	211,663	27,615	13.0%	Medicare Part D Revenue	2,102,376	2,008,099	94,277	4.7%
3,674,281	**4,191,426**	**(517,145)**	**(12.3%)**	**Total Operating Revenue**	**36,302,135**	**39,352,313**	**(3,050,178)**	**(7.8%)**
				Medical Expenses				
1,033,643	1,089,930	56,287	5.2%	Medical Management	9,946,177	11,221,454	1,275,277	11.4%
642,137	983,928	341,791	34.7%	Facilities Claims	7,778,136	9,322,083	1,543,947	16.6%
772,126	989,921	217,795	22.0%	Professional Claims	7,641,663	9,373,666	1,732,003	18.5%
413,076	426,200	13,124	3.1%	Prescription Drugs	4,138,078	4,002,217	(135,861)	(3.4%)
33,233	74,954	41,722	55.7%	MLTSS	1,396,440	692,133	(704,307)	(101.8%)
250,150	198,820	(51,330)	(25.8%)	Patient Transportation	1,907,994	1,912,423	4,429	0.2%
-	6,111	6,111	100.0%	Incentive Payments	(120,875)	58,871	179,746	305.3%
3,144,363	**3,769,864**	**625,501**	**16.6%**	**Total Medical Expenses**	**32,687,613**	**36,582,847**	**3,895,234**	**10.6%**
529,918	**421,562**	**108,356**	**25.7%**	**Gross Margin**	**3,614,523**	**2,769,466**	**845,057**	**30.5%**
				Administrative Expenses				
139,787	167,815	28,028	16.7%	Salaries, Wages & Employee Benefits	1,366,667	1,761,730	395,063	22.4%
1,354	10,412	9,058	87.0%	Professional Fees	4,461	34,123	29,662	86.9%
73,971	58,946	(15,025)	(25.5%)	Purchased Services	291,494	452,063	160,569	35.5%
5,217	10,335	5,118	49.5%	Printing & Postage	188,522	192,442	3,920	2.0%
1,097	900	(197)	(21.9%)	Depreciation & Amortization	8,222	9,000	778	8.6%
20,812	(5,292)	(26,104)	(493.3%)	Other Operating Expenses	108,233	65,367	(42,866)	(65.6%)
13,932	13,284	(648)	(4.9%)	Indirect Cost Allocation, Occupancy	139,316	128,526	(10,790)	(8.4%)
256,170	**256,400**	**230**	**0.1%**	**Total Administrative Expenses**	**2,106,916**	**2,643,251**	**536,335**	**20.3%**
273,747	**165,162**	**108,585**	**65.7%**	**Change in Net Assets**	**1,507,607**	**126,215**	**1,381,392**	**1094.5%**
85.6%	***89.9%***	***(4.4%)***		***Medical Loss Ratio***	***90.0%***	***93.0%***	***(2.9%)***	
7.0%	***6.1%***	***(0.9%)***		***Admin Loss Ratio***	***5.8%***	***6.7%***	***0.9%***	

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CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Ten Months Ending April 30, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
473	**568**	**(95)**	**(16.7%)**	**Member Months**	**4,724**	**5,680**	**(956)**	**(16.8%)**
				Revenues				
210,891	253,517	(42,626)	(16.8%)	Revenue	2,013,015	2,535,170	(522,155)	(20.6%)
210,891	**253,517**	**(42,626)**	**(16.8%)**	**Total Operating Revenue**	**2,013,015**	**2,535,170**	**(522,155)**	**(20.6%)**
				Medical Expenses				
168,428	166,522	(1,906)	(1.1%)	Medical Management	1,545,626	1,665,220	119,594	7.2%
31,160	32,958	1,798	5.5%	Waiver Services	288,845	329,580	40,735	12.4%
168,428	166,522	(1,906)	(1.1%)	Total Medical Management	1,545,626	1,665,220	119,594	7.2%
31,160	32,958	1,798	5.5%	Total Waiver Services	288,845	329,580	40,735	12.4%
199,588	**199,480**	**(108)**	**(0.1%)**	**Total Program Expenses**	**1,834,471**	**1,994,800**	**160,329**	**8.0%**
11,303	**54,037**	**(42,734)**	**(79.1%)**	**Gross Margin**	**178,544**	**540,370**	**(361,826)**	**(67.0%)**
				Administrative Expenses				
81,777	76,515	(5,262)	(6.9%)	Salaries, Wages & Employee Benefits	762,771	801,653	38,882	4.9%
1,333	1,334	1	0.1%	Professional Fees	13,333	13,332	(1)	(0.0%)
5	-	(5)	(100.0%)	Purchased Services	5	-	(5)	(100.0%)
8,009	9,152	1,143	12.5%	Other Operating Expenses	61,782	91,496	29,714	32.5%
5,513	6,550	1,037	15.8%	Indirect Cost Allocation, Occupancy	55,132	65,500	10,368	15.8%
96,638	**93,551**	**(3,087)**	**(3.3%)**	**Total Administrative Expenses**	**893,023**	**971,981**	**78,958**	**8.1%**
(85,335)	**(39,514)**	**(45,821)**	**(116.0%)**	**Change in Net Assets**	**(714,479)**	**(431,611)**	**(282,868)**	**(65.5%)**
94.6%	***78.7%***	***16.0%***		***Medical Loss Ratio***	***91.1%***	***78.7%***	***12.4%***	
45.8%	***36.9%***	***(8.9%)***		***Admin Loss Ratio***	***44.4%***	***38.3%***	***(6.0%)***	

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CalOptima Health
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Ten Months Ending April 30, 2023

Month					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				
44,613	55,650	11,037	19.8%	Purchased Services	423,207	556,500	133,293	24.0%
174,199	224,250	50,051	22.3%	Depreciation & Amortization	1,757,938	2,242,500	484,562	21.6%
30,259	22,500	(7,759)	(34.5%)	Insurance Expense	218,134	225,000	6,866	3.1%
142,263	138,755	(3,508)	(2.5%)	Repair & Maintenance	1,244,690	1,387,550	142,860	10.3%
34,860	48,405	13,545	28.0%	Other Operating Expenses	582,500	484,050	(98,450)	(20.3%)
(426,194)	(489,560)	(63,366)	(12.9%)	Indirect Cost Allocation, Occupancy	(4,226,469)	(4,895,600)	(669,131)	(13.7%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

Note: For consolidation purposes only Rental Income mapped

CalOptima Health
Building 500 - City Parkway
Statement of Revenues and Expenses
For the Ten Months Ending April 30, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
181,333	172,500	8,833	5.1%	Rental Income	1,828,143	1,725,000	103,143	6.0%
181,333	**172,500**	**8,833**	**5.1%**	**Total Operating Revenue**	**1,828,143**	**1,725,000**	**103,143**	**6.0%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
8,870	13,333	4,463	33.5%	Purchased Services	122,727	133,330	10,603	8.0%
34,573	-	(34,573)	(100.0%)	Depreciation & Amortization	345,729	-	(345,729)	(100.0%)
-	2,733	2,733	100.0%	Insurance Expense	-	27,330	27,330	100.0%
47,306	25,666	(21,640)	(84.3%)	Repair & Maintenance	326,591	256,660	(69,931)	(27.2%)
13,516	39,933	26,417	66.2%	Other Operating Expenses	195,096	399,330	204,234	51.1%
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
104,265	**81,665**	**(22,600)**	**(27.7%)**	**Total Administrative Expenses**	**990,143**	**816,650**	**(173,493)**	**(21.2%)**
77,068	**90,835**	**(13,767)**	**(15.2%)**	**Change in Net Assets**	**837,999**	**908,350**	**(70,351)**	**(7.7%)**

OTHER INCOME STATEMENTS – APRIL MONTH:

ONECARE CONNECT INCOME STATEMENT

CHANGE IN NET ASSETS is ($0.9) million, unfavorable to budget $0.8 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.3 million, favorable to budget $0.1 million

MSSP INCOME STATEMENT

CHANGE IN NET ASSETS is ($85,335), unfavorable to budget $45,821

BUILDING 500 INCOME STATEMENT

CHANGE IN NET ASSETS is $0.1 million, unfavorable to budget $13,767

- Net of $0.2 million in rental income and $0.1 million in expenses

INVESTMENT INCOME

- Favorable variance of $11.5 million primarily from $10.0 million of interest income

CalOptima Health
Balance Sheet
April 30, 2023

ASSETS		**LIABILITIES & NET POSITION**	
Current Assets		Current Liabilities	
Operating Cash	$818,209,793	Accounts Payable	$9,214,218
Short-term Investments	1,504,383,432	Medical Claims Liability	1,699,079,684
Capitation Receivable	372,525,675	Accrued Payroll Liabilities	19,300,557
Receivables - Other	95,691,186	Deferred Revenue	7,805,892
Prepaid Expenses	20,738,393	Deferred Lease Obligations	52,304
		Capitation and Withholds	100,795,921
Total Current Assets	**2,811,548,478**	**Total Current Liabilities**	**1,836,248,575**
Capital Assets			
Furniture & Equipment	50,490,439		
Building/Leasehold Improvements	5,299,125		
Construction in Progress	5,982,063		
505 City Parkway West	52,965,722		
500 City Parkway West	22,631,500		
	137,368,849		
Less: Accumulated Depreciation	(70,229,278)	Other Liabilities	
Capital Assets, Net	67,139,571	GASB 96 Subscription Liabilities	-
GASB 96 Capital Assets		Other (than pensions) Post	
GASB 96 Subscription Assets	-	Employment Benefits Liability	22,607,827
		Net Pension Liabilities	577,854
Less: GASB 96 Accumulated Depreciation	-	Bldg 505 Development Rights	-
GASB 96 Capital Assets, Net	-		
Total Capital Assets	67,139,571		
Other Assets			
Restricted Deposit & Other	300,000	**TOTAL LIABILITIES**	**1,859,434,256**
Homeless Health Reserve	-		
Board-Designated Assets:			
Cash and Cash Equivalents	27,164		
Investments	579,882,780	Deferred Inflows	
Total Board-Designated Assets	579,909,944	Excess Earnings	686,563
		OPEB 75 Difference in Experience	4,822,000
		Change in Assumptions	1,909,305
Total Other Assets	580,209,944	OPEB Changes in Assumptions	3,389,000
		Diff in Proj vs Act	20,982,636
		Net Position	
TOTAL ASSETS	**3,458,897,993**	TNE	105,318,495
		Funds in Excess of TNE	1,471,981,331
Deferred Outflows		**TOTAL NET POSITION**	1,577,299,826
Contributions	1,931,845		
Difference in Experience	2,353,671		
Excess Earning	-		
Changes in Assumptions	2,325,077		
OPEB 75 Changes in Assumptions	2,486,000		
Pension Contributions	529,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**3,468,523,586**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**3,468,523,586**

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CalOptima Health
Board Designated Reserve and TNE Analysis
as of April 30, 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	236,099,730				
	Tier 1 - MetLife	234,373,593				
Board-designated Reserve		470,473,324	318,978,450	500,819,997	151,494,874	(30,346,674)
	Tier 2 - Payden & Rygel	54,847,720				
	Tier 2 - MetLife	54,588,901				
TNE Requirement		109,436,620	105,318,495	105,318,495	4,118,126	4,118,126
	Consolidated:	**579,909,944**	**424,296,944**	**606,138,492**	**155,613,000**	**(26,228,548)**
	Current reserve level	*1.91*	*1.40*	*2.00*		

CalOptima Health
Statement of Cash Flows
April 30, 2023

	April	July to April
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	35,547,547	157,831,058
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	262,434	2,295,523
Changes in assets and liabilities:		
Prepaid expenses and other	(2,027,597)	1,853,862
Catastrophic reserves		
Capitation receivable	(1,913,002)	8,647,725
Medical claims liability	(261,435,519)	421,064,335
Deferred revenue	(29,566,081)	(298,153)
Payable to health networks	5,358,512	(92,418,708)
Accounts payable	569,876	(43,102,670)
Accrued payroll	425,954	162,845
Other accrued liabilities	(12,384)	(39,868)
Net cash provided by/(used in) operating activities	(252,790,259)	455,995,949
GASB 68 CalPERS 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	22,169,953	(489,922,929)
Change in Property and Equipment	(268,819)	(2,571,058)
Change in Restricted Deposit & Other	-	51
Change in Board designated reserves	(2,395,244)	(9,418,303)
Change in Homeless Health Reserve	-	40,636,739
Net cash provided by/(used in) investing activities	19,505,890	(461,275,501)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(233,284,369)	(5,279,552)
CASH AND CASH EQUIVALENTS, beginning of period	$1,051,494,162	823,489,344
CASH AND CASH EQUIVALENTS, end of period	**818,209,793**	**818,209,793**

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BALANCE SHEET – APRIL MONTH:

ASSETS of $3.5 billion decreased $249.1 million from March or 6.7%

- Operating Cash and Short-term Investments net decrease of $255.5 due to $272 million of Hospital Directed Payments (DP) and the timing of cash receipts and claims payments activity

LIABILITIES of $1.9 billion decreased $284.7 million from March or 13.3%

- Claims Liabilities decreased $261.4 million primarily due to the payout of Hospital DP
- Deferred Revenue decreased $29.6 million due to timing of capitation payments from the Centers for Medicare & Medicaid Services (CMS)
- Capitation and Withholds increased $5.4 million

NET ASSETS of $1.6 billion, increased $35.5 million from March or 2.3%

CalOptima Health - Consolidated
Net Assets Analysis
For the Ten Months Ended April 30, 2023

Category	Item Description	Amount (millions)	Approved Initiative	Spend to Date	%
	Total Net Position @ 4/30/2023	**$1,577.3**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**579.9**			**36.8%**
	Capital Assets, net of depreciation	**67.1**			**4.3%**
Resources Allocated[2]	Homeless Health Initiative[3]	$21.5	$59.9	$38.4	1.4%
	Housing and Homelessness Incentive Program[4]	40.8	52.7	11.9	2.6%
	Intergovernmental Transfers (IGT)	59.1	111.7	52.6	3.7%
	Digital Transformation and Workplace Modernization	91.5	100.0	8.5	5.8%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	Outreach Strategy for CalFresh, Redetermination support, and other programs	7.0	8.0	1.0	0.4%
	Coalition of Orange County Community Health Centers Grant	40.0	50.0	10.0	2.5%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	1.0	1.0	0.0	0.1%
	General Awareness Campaign	1.1	2.7	1.6	0.1%
	Member Health Needs Assessment	1.0	1.0	0.0	0.1%
	Five-Year Hospital Quality Program Beginning MY 2023	153.5	153.5	0.0	9.7%
	Medi-Cal Annual Wellness Initiative	15.0	15.0	0.0	1.0%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.6%
	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	5.0	5.0	0.0	0.3%
	Community Living and PACE Center in the City of Tustin	18.0	18.0	0.0	1.1%
	Subtotal:	**$466.5**	**$606.5**	**$140.0**	**29.6%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$463.7**			**29.4%**

[1] Total of Board Designated reserve and unallocated reserve amount can support approximately 103 days of CalOptima Health's current operations

[2] Initiatives that have been paid in full in the previous year are omitted from the list of Resource Allocated

[3] See Page 30 for Summary of Homeless Health Initiative and Allocated Funds for list of Board approved initiatives

[4] On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP (see HHIP Summary on Page 31)

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CalOptima Health
Key Financial Indicators
As of April 30, 2023

Income Statement

Item Name	Month-to-Date (April 2023) Actual	Budget	Variance	%		FY 2023 Year-to-Date (April 2023) Actual	Budget	Variance	%	
Member Months	984,986	904,826	80,160	8.9%		9,525,453	9,119,235	406,218	4.5%	
*Operating Revenue **	348,999,375	327,387,553	21,611,822	6.6%		3,472,811,712	3,329,332,586	143,479,126	4.3%	
*Medical Expenses **	308,989,504	307,082,756	(1,906,748)	(0.6%)		3,214,447,060	3,121,837,529	(92,609,531)	(3.0%)	
General and Administrative Expense	15,675,690	18,766,126	3,090,436	16.5%		151,833,358	180,917,657	29,084,299	16.1%	
Non-Operating Income/(Loss)	11,213,366	(1,487,087)	12,700,453	854.0%		51,299,764	(9,935,804)	61,235,568	616.3%	
Summary of Income & Expenses	35,547,547	51,584	35,495,963	68,812.0%		157,831,058	16,641,596	141,189,462	848.4%	

Ratios

Medical Loss Ratio (MLR)	Actual	Budget	Variance		Actual	Budget	Variance	
Consolidated	88.5%	93.8%	(5.3%)		92.6%	93.8%	(1.2%)	

Administrative Loss Ratio (ALR)	Actual	Budget	Variance		Actual	Budget	Variance	
Consolidated	4.5%	5.7%	1.2%		4.4%	5.4%	1.1%	

Investment

Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
@4/30/2023	2,074,740,140	2,091,748,138	(17,007,998)	(0.8%)

Unallocated/Unassigned Reserve Balance	Current Month	Fiscal Year Ending June 2022	Change	%
Consolidated	463,733,058	448,294,548	15,438,510	3.4%
*Days Cash On Hand***	103			

Key:	
> 0%	
> -20%, < 0%	
< -20%	

*$293M of Directed Payments (DP) are included in YTD revenue and $291M of DP are included in YTD expenses.

**Total of Board Designated reserve and unallocated reserve amount can support approximatley 103 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 Ten Months Ended April 30, 2023

	FY 2022-23 Month-to-Date				FY 2022-23 Year-to-Date			
	Actual Spend	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**
Capital Assets (Cost, Information Only):								
Total Capital Assets	**374,861**	**291,666**	**(83,195)**	**-28.5%**	**4,405,241**	**36,512,666**	**32,107,425**	**87.9%**
Operating Expenses:								
Salaries, Wages & Benefits	463,878	486,916	23,038	4.7%	2,219,987	4,227,332	2,007,345	47.5%
Professional Fees	-	186,041	186,041	100.0%	118,650	1,860,410	1,741,760	93.6%
Purchased Services	-	50,833	50,833	100.0%	-	208,330	208,330	100.0%
Depreciation Expenses	-	-	-	0.0%	-	-	-	0.0%
Other Expenses	348,099	274,365	(73,734)	(26.9%)	1,726,492	2,743,650	1,017,158	37.1%
Total Operating Expenses	**811,977**	**998,155**	**186,178**	**18.7%**	**4,065,130**	**9,039,722**	**4,974,592**	**55.0%**

Funding Balance Tracking:	**Actual Spend**	**Approved Budget**
Beginning Funding Balance	100,000,000	100,000,000
Less:		
FY2022-23	8,470,370	47,973,113
FY2023-24		
FY2024-25		
Ending Funding Balance	**91,529,630**	**52,026,887**

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Summary of Homeless Health Initiatives and Allocated Funds
As of April 30, 2023

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 & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,434,060	565,940
CalOptima Days, HCAP and FQHC Administrative Support	963,261	640,753	322,508
FQHC (Community Health Center) Expansion	21,902	21,902	-
Homeless Clinical Access Program (HCAP) and CalOptima Days	9,888,914	3,170,400	6,718,514
Vaccination Intervention and Member Incentive Strategy	400,000	54,649	345,351
Street Medicine	8,000,000	1,455,500	6,544,500
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)*	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$ 100,000,000**	**$ 38,403,187**	**$ 61,596,813**
Transfer of funds to HHIP	(40,100,000)	-	(40,100,000)
Program Total	**$ 59,900,000**	**$ 38,403,187**	**$ 21,496,813**

Note:

*On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP

Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds
As of April 30, 2023

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Office of Care Coordination	2,200,000	-	2,200,000
Pulse For Good	800,000	-	800,000
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations	3,021,311	1,396,149	1,625,162
Infrastructure Projects	5,832,314	2,577,032	3,255,282
Capital Projects	40,212,839	7,948,340	32,264,499
Total of Approved Initiatives	**$ 52,666,464**	**$ 11,921,521**	**$ 40,744,943**

Note:

Total funding $52.7M: $40.1M Board approved transfer from CalOptima Homeless Health Initiatives and $12.6M from DHCS HHIP incentive payment

CalOptima Health
Budget Allocation Changes
Reporting Changes for April 2023

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
August	Medi-Cal	Health Reward Incentive Fulfillment	Health Reward Incentive Fulfillment	$75,000	To reallocate funds from Purchased Services – Health Reward Incentive Fulfillment to Incentive Budget for PHM Health Rewards	2022-23
October	Medi-Cal	Quality Improvements - Professional Fees - Consultants for NCQA Accreditation	Quality Improvements - Subscriptions - CAQH Application Subscription - Credentialing Database	$75,000	To reallocate funds from Professional Fees – Consultants for NCQA Accreditation to Subscriptions – CAQH Application Subscription – Credentialing Database to provide additional funding for expanding scope of services	2022-23
November	OneCare	Customer Service - Member Communication	Cultural & Linguistic Services - Purchased Services	$75,000	To reallocate funds from OC Customer Service – Member Communication to OC Cultural & Linguistic Services – Purchased Services to provide additional funding for translation of documents due to OCC/OC transition	2022-23
November	Medi-Cal	Human Resources - Cert/Cont. Education	Human Resources - Training & Seminars	$10,000	To reallocate funds from HR Onsite Computer Classes to Training & Seminars, HR Staff Development (for the CPS Academy classes)	2022-23
November	Medi-Cal	Population Health Management - Professional Fees	Case management - Training & Seminars	$27,000	To reallocate funds from Population Health Management – Purchased Services to Case Management – Training & Seminars to provide funding for WPATH training	2022-23
December	Medi-Cal	Quality Improvements - Subscriptions	Quality Improvements - Purchased Services	$75,000	To reallocate funds from Subscriptions – CAQH Application Subscription – Credentialing Database to Purchased Services to provide funding for additional credentialing services with a new vendor	2022-23
December	Medi-Cal	Communications - Purchased Services	Communications - Public Activities	$10,000	To reallocate funds from Purchased Services to Public Activities to provide funding for additional Medi-Cal Campaigns Support	2022-23
December	Medi-Cal	Population Health Management - Purchased Services	Quality Improvements - Purchased Services	$24,950	To reallocate funds from Population Health Management – Purchased Services to Quality Improvement – Purchased Services to provide additional funding for CVO credentialing services	2022-23
December	PACE	Capital: Interior Light Improvement	Capital: Additional Furniture, Fixtures and Equipment	$35,000	To reallocate funds from Interior Light Improvement to Additional Furniture Fixtures	2022-23
January	Medi-Cal	Facilities - Comp Supply/Minor Equipment	Facilities - R&M Building	$70,000	To reallocate funds from Facilities Comp Supply/Minor Equipment to Facilities R&M Building to cover any remaining purchases that will be incurred in FY23.	2022-23
January	OCC	Sales & Marketing - Printing & Postage	Cultural & Linguistic Services - Purchased Services	$18,000	To reallocate funds from Sales & Marketing Printing Postage & Customer Service Postage to Cultural Linguistic Purchased OCC-803 (C&L translations/interpreter services) needed an additional $58K to pay outstanding invoices.	2022-23
January	OCC	Customer Service - Postage	Cultural & Linguistic Services - Purchased Services	$40,000	To reallocate funds from Sales & Marketing Printing Postage & Customer Service Postage to Cultural Linguistic Purchased OCC-803 (C&L translations/interpreter services) needed an additional $58K to pay outstanding invoices.	2022-23
January	OC	Sales & Marketing - Purchased Services General	Cultural & Linguistic Services - Purchased Services	$50,000	To reallocate funds from Sales & Marketing - Purchased Services to Cultural & Linguistic - Purchased Services for translations/interpreter services.	2022-23
January	Medi-Cal	Medical Management - Food Services	Medical Management - Professional Dues	$12,000	To reallocate funds from Medical Management Food Services to Medical Management Professional Dues to pay for Orange County Medical Association dues for the Medical Directors.	2022-23
February	Medi-Cal	Capital: Building Security Projects	Capital: Office Suite Renovation & Improvements	$150,000	To reallocate funds from Facilities Building Security Projects to Facilities Office Suite Renovation for Improvements for 8th Floor HR renovation, 9th Floor Office renovation, 9th Floor hallway renovation and Directory signage.	2022-23
February	Medi-Cal	Facilities - Comp Supply/Minor Equipment	Facilities - R&M Building	$70,000	To reallocate funds from Facilities Comp Supply/Minor Equipment to Facilities R&M Building to cover any remaining purchases that will be incurred in FY23.	2022-23
February	Medi-Cal	Capital: Building Security Projects	Capital: Electric Car Charging Station	$30,000	To reallocate funds from Facilities Building Security Projects to Facilities Electric Car Charging Station.	2022-23
February	Medi-Cal	Renaming Capital : Touchless Faucet	Capital - 9th Floor Improvement	$183,000	To re-name and re-purpose to meet new fire code requirements for fire exiting on the 9th floor.	2022-23
February	OC	Sales & Marketing - Purchased Services General	Financial Analysis - Professional Fees	$30,000	To reallocate funds from Sales & Marketing Purchased Services to Financial Analysis Professional Fees for OneCare VBID Model.	2022-23
February	PACE	PACE Center Support - Repair & Maintenance	PACE Administrative - Professional Fees	$50,000	To reallocate funds from PACE Center Support Repair & Maintenance to PACE Administrative Professional Fees for anticipated PACE audit.	2022-23
March	OC	Sales & Marketing - Purchased Services General	IS Application Management - Purchased Services	$80,000	To reallocate funds from Sales & Marketing Purchased Services to IS Application Management Purchased Services to support WIPRO/Infocrossing testing of Edifecs files.	2022-23
March	Medi-Cal	Population Health Mgmt. - Purchased Services General	Quality Analytics - Purchased Services General	$200,000	To reallocate funds from Population Health Management Purchased Services to Quality Analytics Purchased Services for 5 Star Rating Medicare Member Engagement.	2022-23
March	OC	Sales & Marketing - Purchased Services General	Sales & Marketing - Public Activities	$35,000	To reallocate funds from Sales & Marketing Purchased Services to Sales & Marketing Public Activities for OneCare branded promotional items.	2022-23
March	Medi-Cal	Government Affairs - Training & Seminars	Government Affairs - Professional Fees	$10,000	To reallocate funds from Government Affairs Training & Seminars to Government Affairs Professional Fees due to funding shortfall for the short-term Government Affairs consulting contract with Strategies 360.	2022-23
March	Medi-Cal	IS - Application Mgmt. - Maintenance HW/SW	Human Resources - Professional Fees	$100,000	To reallocate funds from IS Application Management - Maintenance HW/SW to Human Resources Professional Fees for Recruiting Services.	2022-23
March	Medi-Cal	Capital: Migrate Data Warehouse/Analytics to the Cloud	Capital: DTS Planning and Executive Support - Cloud Migration Strategy Professional Services	$235,000	To reallocate funds for the shortfall of the DTS Cloud Migration Strategy Professional Services.	2022-23
March	Medi-Cal	Capital: Migrate Data Warehouse/Analytics to the Cloud	Capital: DTS Planning and Executive Support - Vital Group Redlines for Agent Portal	$220,000	To reallocate funds for the shortfall of the DTS Cloud Migration Strategy Professional Services.	2022-23
April	Medi-Cal	Capital: Facilities Road Warning Light Crosswalk	Capital: Facilities Electric Car Charging Station	$50,000	To reallocate funds from Facilities Road Warning Light (Crosswalk) to Facilities Electric Car Charging Station.	2022-23
April	Medi-Cal	Capital: Facilities IDF Room HVAC Replacement	Capital: Facilities Office Suite Renovations	$40,000	To reallocate funds from Facilities IDF Room HVAC Replacement to Facilities Office Suite Renovations due to additional office space.	2022-23
April	Medi-Cal	Capital: Facilities - Freight Elevator	Capital: Parking Lot Improvement	$42,000	To reallocate funds from Facilities Freight Elevator to Parking Lot Improvement.	2022-23

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.

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Board of Directors Meeting
June 1, 2023

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 Audit & Oversight department, 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. OneCare/OneCare Connect/PACE

- **2023 DHCS PACE Audit *(applicable to PACE)*:**

  - On February 22, 2023, CalOptima Health was formally engaged by DHCS for the PACE Program Audit.
    - CalOptima Health's PACE plan was last audited by both the Centers for Medicare and Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) in 2018. CMS did not participate in the 2023 audit.
    - The following areas were included in the scope of the audit: Grievance documentation procedures, Clinical Appropriateness and Care Planning, Transportation, Personnel Records, Subcontractor Agreements, Serious Incident Reports, Onsite Review of the facility, Emergency Preparedness, Meal preparation and kitchen procedures.
    - The Audit was conducted from April 10, 2023, through April 21, 2023, with the onsite review from April 11, 2023, through April 13, 2023.
  - Exit conference was conducted on April 21, 2023.
  - Audit Findings Report was provided on April 28, 2023, with findings noted in the following areas:
    - Employee Requirements
    - Employee Records
    - Nutrition Services – Food Storage
    - Nutrition Services – Food Sanitation
    - Service Delivery – Provision of Services
    - Medical Records
    - Participant Assessment
  - CalOptima Health's PACE team is currently working on completing the corrective action plan (CAP). The due date to submit the CAP to DHCS is May 29, 2023.

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- **2021 Centers for Medicare & Medicaid Services (CMS) Program Audit/Independent Validation Audit (IVA)/2023 Revalidation Audit *(applicable to OC and OCC)*:**

  - This audit is being conducted to validate that issues identified in the 2021 CMS Routine Program Audit of CalOptima Health have been successfully remediated. There are two final issues going through validation.
    - Formulary Administration (FA) #2.06
      - Successfully validated by CMS on May 5, 2023.
    - Special Needs Plan – Model of Care (SNP-MOC) #5.41
      - Validation to be conducted by independent validation auditor July 20, 2023.
      - Final report to CMS due August 9, 2023.

- **2023 Medicare Part C and Data Part D Data Validation Audit (MDVA) *(applicable to OC)*:**

  - CMS requires Sponsors to participate in a yearly independent review to validate data reported to CMS per the Medicare Part C and Part D Reporting Requirements.
  - CalOptima Health is required to contract with an independent auditor approved by CMS.
  - The audit includes the following Medicare Parts C and D measures:
    - Part C and D Grievances
    - Organization Determinations and Reconsiderations
    - Coverage Determinations and Redeterminations
    - Medication Therapy Management (MTM) Program
    - Special Needs Plan (SNP) Care Management
    - Improving Drug Utilization Review (IDUR) Controls
  - The audit is currently in progress with no issues identified at this point.
  - The audit is scheduled to conclude by June 16, 2023.
  - The final report is to be submitted to CMS by June 30, 2023.

2. Medi-Cal

- **2024 Managed Care Plan (MCP) Operational Readiness Contract:**

  Update:

  As of May 1, 2023, CalOptima Health has **submitted a total of 155 deliverables** for 2024 MCP operational readiness. To date, CalOptima Health has received **approval for 124** items. The remaining deliverables are awaiting a response from the Department of Health Care Services (DHCS) or under review by CalOptima Health as part of an additional information request made by DHCS.

  On-track for all remaining deliverables.

Background – FYI Only

Throughout CY 2022 and CY 2023, MCPs, including CalOptima Health will be required to submit a series of contract readiness deliverables to DHCS for review and approval. Staff will implement the broad operational changes and contractual requirements outlined in the Operational Readiness agreement to ensure compliance with all requirements by January 1, 2024, contract effective date.

- **2023 DHCS Routine Medical Audit:**

***Update**:* No updates since the May 4, 2023, Board Report.
Audit has concluded; CalOptima Health awaits draft findings report.

***Annual (routine) Audit**:*

- Scope included:
  - Utilization management
  - Case management and coordination of care
  - Availability and accessibility
  - Member rights
  - Quality management
  - Administrative and organizational capacity
- Staff interviews concluded; audit remains open
  - Interviews were conducted February 27 through March 3, 2023
  - DHCS hosted a soft exit on March 2, 2023
    - No preliminary findings will be shared with the Plan
    - All findings will be noted in the draft findings report which they hope to provide within three months (~June 2023)

Next Steps:

- CalOptima Health will receive the draft findings report 1-2 days prior to the (to be scheduled) Exit Conference.
- CalOptima Health will have 15 calendar days (from the day of the Exit Conference) to review the findings and submit any rebuttals.
- Once the findings report is finalized by DHCS, a formal request for corrective action will be communicated.

Although DHCS did not identify observations, RAC will proactively begin outreach and engagement to ensure mitigation and resolution to areas of opportunity, identified during the audit prep and interviews, are remediated.

Focused Audit:

- Scope included:
  - Transportation
  - Behavioral Health
- Staff interviews were conducted February 27 through March 8, 2023.
- No soft exit.
- Once DHCS concludes its focused audit reviews of all MCPs, a report is anticipated to be released by Q2 2024. More information to follow as DHCS finalizes and communicates next steps.

Background – FYI Only

- Key points/dates:
  - Lookback-period: 2/1/22 - 1/31/23
  - Line of Business: Medi-Cal (including SPD and Non-SPD population), OneCare Connect
  - Delegate Impact: Yes, Monarch was selected to participate
  - Audit Interviews: 2/27/23 - 3/10/23, will occur virtually
  - Entrance Conference: 2/27/23 at 9:00am, will occur virtually
  - Provider Office Impact: Yes. The audit will also involve facility site visits and medical record review; this means potential impact to Provider offices.

- **2021 DHCS Medical Audit:**

  Update: April CAP update was submitted to DHCS timely. May update is on-track.

  On December 22, 2022, CalOptima Health submitted its formal corrective action plan (CAP) to DHCS. CalOptima Health must provide **monthly updates** on findings with future milestones. These monthly updates will continue until all milestones have been reached and/or DHCS determines the CAP is closed. CalOptima Health's February update was provided to DHCS timely, and CalOptima Health is on-track for a timely March update.

- **2022 Managed Care Entity (MCE) Program Integrity (PI) Review:**

  Update: No updates.

  Background – FYI Only
  - April 13, 2022, the DHCS notified CalOptima Health that it had been selected to provide feedback to CMS in respect to CalOptima Health's internal PI efforts that are in place to ensure adequate oversight as well as to deter and address FWA.
  - Review period was the preceding 3 Federal Fiscal Year (FFYs).
  - Focused on CalOptima Health's Medi-Cal program. DHCS requested that CalOptima Health respond to a series of questions within the CMS Template and submit responses and supporting documentation to DHCS, which DHCS would then submit to CMS.
  - May 4, 2022, CalOptima Health provided its timely response to DHCS.
  - On 10/27/22, CalOptima Health met virtually with CMS & DHCS to discuss the internal PI efforts in place to ensure adequate oversight, as well as to deter and address fraud, waste, and abuse.
    - As requested by the auditors, CalOptima Health submitted a number of supporting documents and narrative responses by 11/10/22.

B. Regulatory Notices of Non-Compliance

- CalOptima Health did not receive any notices of non-compliance from its regulators for the month of April 2023.

C. Updates on Internal and Health Network Monitoring and Audits

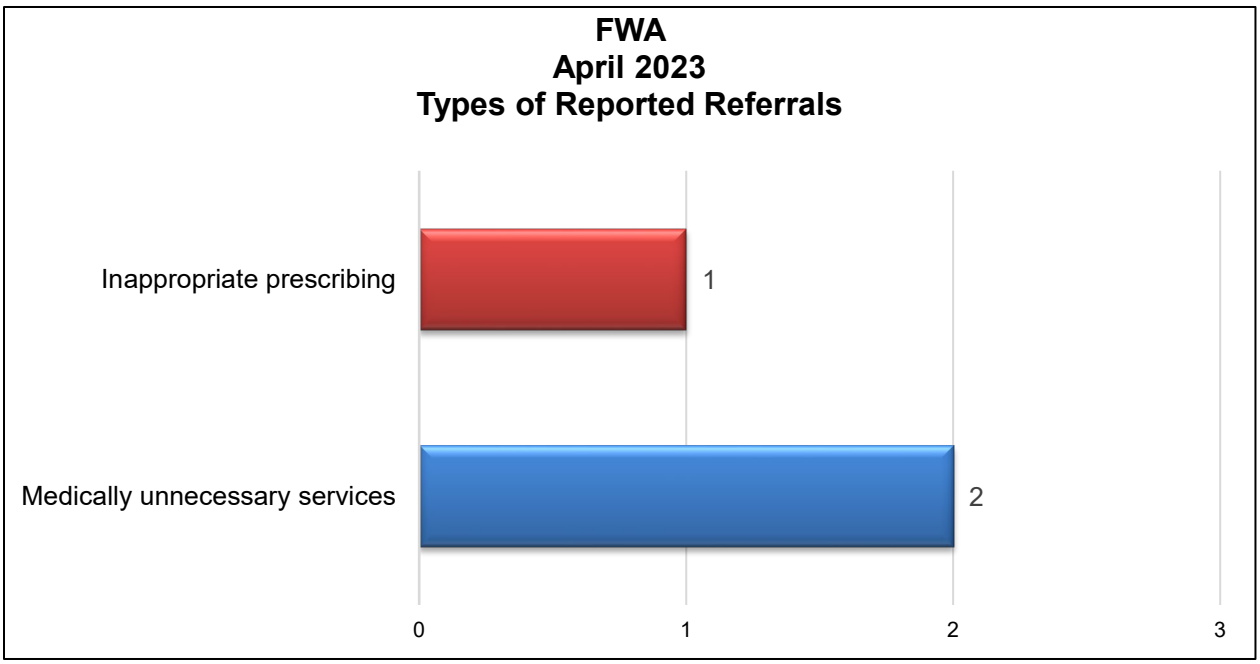
- **Health Network Audits:**

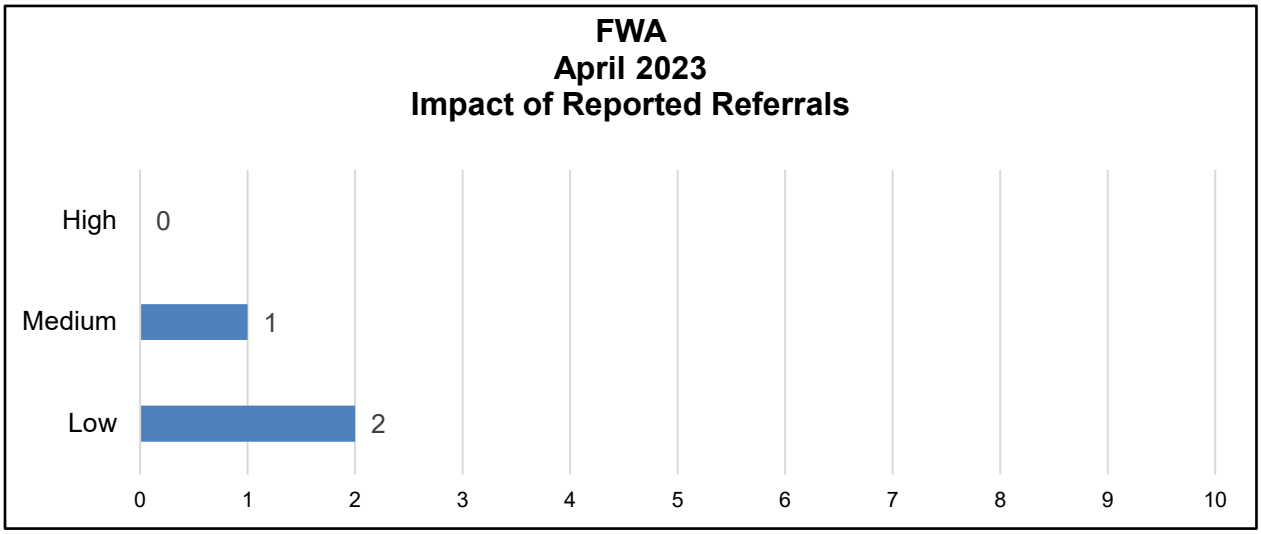
  - CalOptima Health's Audit and Oversight (A&O) department completed annual audits on the following delegated health networks to assess their capabilities and performance with delegated activities:

    - Family Choice Medical Group (FCMG) March 1, 2022, to December 31, 2022

  - Audit tools and elements were derived from accrediting, regulatory and CalOptima Health contractual standards. For areas that scored below the 100% threshold, A&O issued a corrective action plan (CAP) request and is actively working with each health network to remediate findings.
  - The audit included review of specific P&Ps and sample files.
  - A number of areas were identified as opportunities to improve processes and timeliness of notifications to achieve 100% compliance.
  - FCMG has submitted Corrective Action Plans for all findings and is in the process of implementing the corrective actions.
  - CalOptima Health will validate the effectiveness of corrective actions once implementation is complete.

D. Fraud, Waste & Abuse (FWA) Investigations (April 2023)

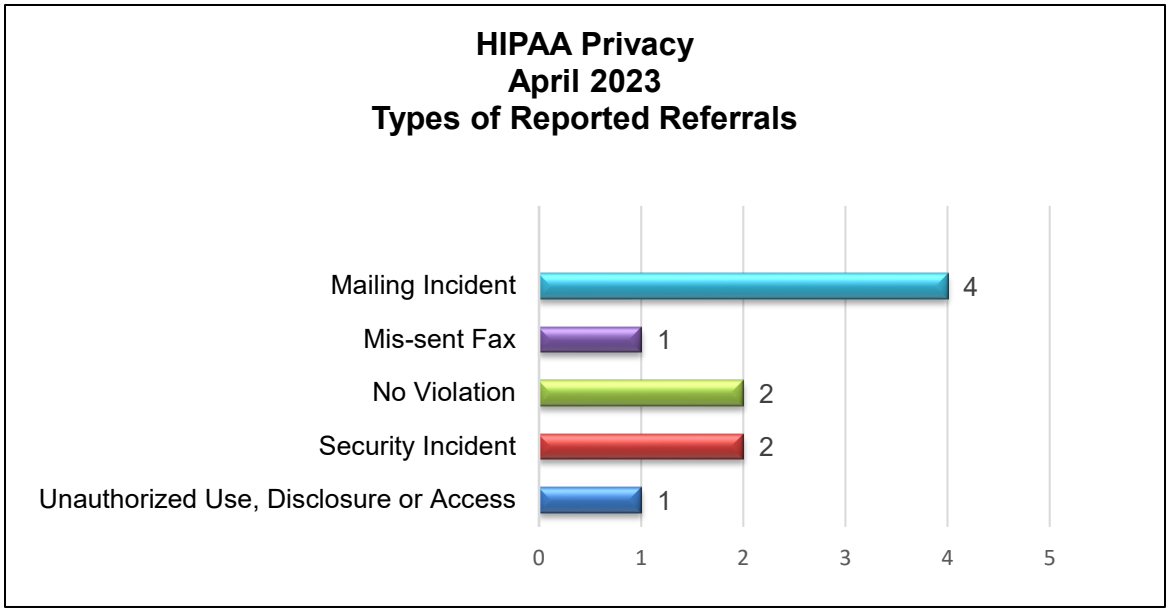


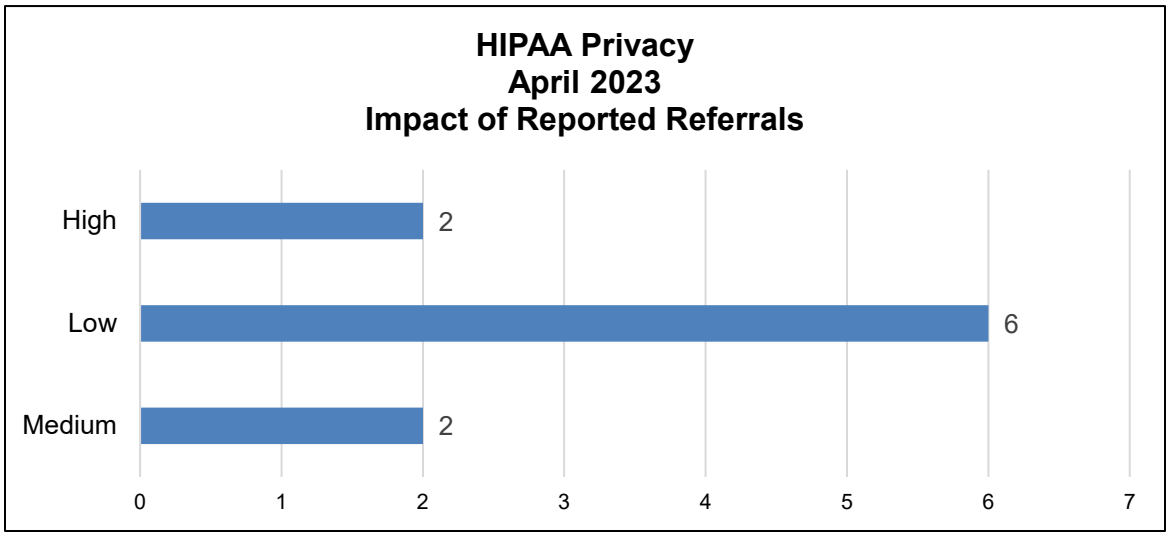


Total Number of New Cases Referred to DHCS (State)	3
Total Number of New Cases Referred to DHCS and CMS*	2
Total Number of Referrals (Subjects) Reported to Regulatory Agencies	**3**

*Effective January 1, 2022, CMS implemented a new portal to report suspicious FWA. Any potential FWA *with impact to Medicare* is reported to both DHCS and CMS at the start of an investigation.

E. Privacy Update: (April 2023)





PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	10
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

POTOMAC PARTNERS DC

STRATEGIC HEALTH CARE

M E M O R A N D U M

May 12, 2023

To: CalOptima Health

From: Potomac Partners DC & Strategic Health Care

Re: May Board of Directors Report

DEBT LIMIT NEGOTIATIONS

On April 26th, House Republicans passed the *Limit, Save, Grow Act of 2023* by a vote of 217-215, with only four Republicans voting against the measure. The legislation would suspend the debt ceiling through either March 31st, 2024, or raise the limit by $1.5 trillion above the current $31.4 trillion ceiling, whichever occurs first. If enacted, it would also limit new discretionary spending by capping FY24 spending at FY22 levels while capping annual federal spending growth at 1% each year for the next decade. The bill would also rescind unspent COVID-19 relief funds and repeal most new tax incentives included within President Biden's *Inflation Reduction Act of 2023 (IRA)*, including energy and climate tax credits. It would also expand work requirements in safety net programs, including the Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP). An analysis by HHS of the impacts this would have in California, sorted by County, is available here.

The bill is unlikely to be considered in the Senate, with nearly all Senate Democrats voicing opposition and the White House already issuing a statement saying the President would veto it if it reached his desk. Despite this, the bill served as a starting point for House Republicans in negotiations with Democrats. On May 9th, House Speaker McCarthy (R-CA), Senate Majority Leader Schumer (D-NY), and President Biden met to discuss a debt limit solution. As of this report, Congressional staff are reportedly working on details discussed during the meeting, indicating that some progress may have been made towards a deal to avert a debt crisis.

After the House passed the Republican debt limit proposal, U.S. Secretary of the Treasury Janet Yellen sent a letter to House Speaker McCarthy regarding the debt ceiling timeline, saying the federal government could reach the debt ceiling as soon as June 1st. The full letter is available here.

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Fiscal Year 2024 (FY24) Appropriations

U.S. Secretary of Health and Human Services (HHS) Xavier Becerra testified on the President's FY24 budget request before the House Labor-HHS-Education Subcommittee in April. Subcommittee Chairman Aderholt (R-AL) expressed his desire to reduce the proposed budget and eliminate certain programs related to gender ideology and abortion. Rep. LaTurner (R-KS) discussed the Provider Relief Fund, specifically the formula used to disburse funding. Secretary Becerra expressed concern with the idea of clawing back Provider Relief Funds from the early tranches. The full budget hearing is available here. The Secretary's written testimony is available here.

The House and Senate are expected to begin releasing the text of draft FY24 spending bills as soon as the week of May 22nd. Once the draft bills are released, the Subcommittees will begin holding markups to make amendments and technical corrections.

Public Health Emergency (PHE) Designation Ends

The federal PHE for COVID-19 expired on May 11th, 2023. Most major telehealth flexibilities will not be affected, nor the Food and Drug Administration's (FDA) Emergency Use Authorizations (EUAs) for COVID-19 products (including tests, vaccines, and treatments). Regarding programs that have ended, a fact sheet on certain Medicare and Medicaid waivers and broad flexibilities for health care providers is available here. CMS has also released updated factsheets for Medicare Advantage plans (here), Federally Qualified Health Centers (FQHCs)(here), and other entities that may have been using COVID-19 waivers and flexibilities (here).

DEA Reverses Decision on Telehealth Rules for Controlled Substances

After receiving more than 40,000 comments against the proposed rule that would have ended telehealth flexibilities for prescriptions for controlled substances, the Drug Enforcement Agency (DEA) announced that it would extend the rules, sending a "*Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications*" to the White House Office of Management and Budget. The DEA put out a statement on the decision before the rule was released, saying, "We recognize the importance of telemedicine in providing Americans with access to needed medications, and we have decided to extend the current flexibilities while we work to find a way forward to give Americans that access with appropriate safeguards." The OMB listing is available here. The DEA press release is available here.

CMS 2024 Notice of Benefit and Payment Parameters

The Centers for Medicare & Medicaid Services (CMS) released the 2024 Notice of Benefit and Payment Parameters this week. Beginning January 1, 2024, Federally-Facilitated Marketplaces (FFMs) and State-Based Marketplaces (SBMs) will have the option to implement a new Special Enrollment Period for people losing Medicaid or CHIP coverage, allowing consumers to select a plan for Marketplace coverage 60 days before, or 90 days after, losing Medicaid or CHIP coverage. The final rule also limits the number of non-standardized plan options offered by issuers of Qualified Health Plans through the FFMs and SBMs on the Federal Platform (SBM-FPs) to four in each area for the 2024 plan year. The HHS press release is available here, along with the CMS factsheet here.

CMS Proposed Rules on Access and Transparency in Medicaid & Children's Health Insurance Program (CHIP)

On April 27th, CMS announced two notices of proposed rulemaking, the *Ensuring Access to Medicaid Services* (Federal Register) and the *Managed Care Access, Finance, and Quality* (Federal Register). The agency states that the rules would "strengthen access and quality of care across Medicaid and the Children's Health Insurance Program (CHIP)" and "establish historic national standards for access to care regardless of whether that care is provided through managed care plans or directly by states through fee-for-service (FFS)." If finalized as proposed, the rules would establish a national standard for wait times, require states to conduct secret shopper assessments, require the disclosure of provider payment rates in both fee-for-service and managed care, and establish a framework for a Medicaid and CHIP quality rating system for comparing managed care plans. The proposed rules and relevant factsheets are hyperlinked below:

- Summary of CMS's Access-Related Notices of Proposed Rulemaking
- Summary of Medicaid and CHIP Payment-Related Provisions
- Summary of Key Home and Community-Based Services (HCBS) Provisions
- Factsheet: Medicaid or Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality NPRM

HHS Proposal to Expand Health Care for DACA Recipients

On April 26th, HHS issued a Proposed Rule that would allow Deferred Action for Childhood Arrivals (DACA) recipients to qualify for a Special Enrollment Period to select a Qualified Health Plan through a Marketplace for 60 days after the rule is made final. The proposed change applies to the Health Insurance Marketplaces, the Basic Health Program, and some Medicaid and CHIP programs. The Proposed Rule (2023-08635) is available here. A White House fact sheet on *Expanding Health Coverage to DACA Recipients* is available here.

CMS Letter to State Directors Encouraging Use of New 1115 Demonstration

According to CMS, the new Medicaid Reentry Section 1115 Demonstration Opportunity would allow state Medicaid programs to cover services that address various health concerns, including substance use disorders and other chronic health conditions. The letter, which includes guidance to interested states, encourages demonstrations that will facilitate continuity of care for individuals transitioning from incarceration and employ innovative service delivery systems. The full letter is available here. California's application for a 1115 demonstration amendment was approved in January 2023. More information about California's demonstration is available here.

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate Bridget E. McGowan Associate

May 19, 2023

CalOptima Health
LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

General Update

The Legislature wrapped up two major legislative deadlines in the last several weeks.

The policy committee deadline was April 28, and the weeks preceding this deadline are arguably the busiest of the Legislative session, as committees work to analyze and hold hearings for most of the bills introduced thus far while simultaneously conducting hearings on the proposed state budget. Non-fiscal bills had until May 5 to be heard in policy committee.

May 19 was another legislative milestone: the fiscal committee deadline, where fiscal bills must be heard in the Appropriations Committee in the first house before going to a vote on the floor. On May 18, the Appropriations Committees in both houses held their "suspense hearing," where they dispensed hundreds of bills on the "suspense file" at once. It is at this point in the legislative process where we see the number of active bills moving through the legislative process decrease, and this year was no exception with many bills being held in the Committee.

Bills must next be voted upon on the Floor of the House of Origin by June 2.

Budget Update. The Governor released the May Revision of the 2023-24 Budget late last week. As anticipated, the May Revision projects an increased deficit of $31.5 billion, up from the figure in January. Given the delayed tax filing deadline, the revenue picture will remain largely uncertain.

The May Revision includes the Managed Care Organizations (MCO) tax proposal which would result in $19.4 billion of revenue. Along with using this revenue for Medi-Cal investments, the proposal would allocate over $8 billion of the funding to the General Fund to help balance the budget. We anticipate that this will be a point of concern within the provider community and a focus of debate in the coming weeks.

The Governor and Legislature must agree on a budget by the June 15 constitutional deadline. Given the revenue uncertainty, we anticipate budget discussions will continue after the budget is formally adopted.

Legislation of Interest

AB 271 (Quirk-Silva) - Homeless Death Review Committee. This bill would allow counties to establish a homeless death review committee to gather information to identify the root causes of death of homeless individuals as well as determine strategies to improve the coordination of services for this population.

AB 271 passed out of the Assembly in early March and is now in the Senate.

CalOptima Health supports this bill.

AB 1230 (Valencia) - Special Needs Plans. This measure directs the Department of Health Care Services to offer contracts to health care service plans for Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) to provide care to dual eligible beneficiaries. Most County Organized Health Systems have expressed concerns with this bill because it circumvents COHS authority to exclusively contract with providers in their services areas.

This bill is a two-year bill.

SB 598 (Skinner) - Prior Authorization. This bill would prohibit insurance plans from requiring contracted physicians and other health professionals to get prior authorization for any covered services if the plan approved or would have approved no less than 90% of prior authorization requests in the last one-year contract period.

The bill passed out of the Senate Health Committee this month, with the author accepting various committee amendments that encourage providers and plans towards a 2018 agreement to improve prior authorization.

Commercial health plans are opposing SB 598, while some public health plans are seeking amendments, but appear ready to formally oppose as negotiations have not resulted in a favorable outcome.

The bill passed out of the Senate Appropriations Committee on May 18.

SB 870 (Caballero) - MCO Tax Renewal. This bill would renew the managed care organization (MCO) tax. Negotiations continue to determine how long the tax will last, which entities are taxed and at what rates, and how the revenue is spent. Hospitals and physicians are pushing to earmark the revenue for Medi-Cal rate increases.

The bill was held in the Senate Appropriations Committee on May 18 – a sign that the topic will instead be dealt with as part of the budget process.

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2023–24 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
S. 923 Bennet (CO)	**Better Mental Health Care for Americans Act:** Would require parity for mental health services in Medicaid, MA, and Medicare Part D. Would also enhance Medicaid and Medicare payments for integrating mental health and substance use disorder services with physical care Finally, would create a 54-month Medicaid demonstration project to increase state funding for enhanced access to mental health services for children. In addition, would require MA plans to verify and update provider directories at least every 90 days and remove a non-participating provider within two business days of notification. ***Potential CalOptima Health Impact**:* Increased access to behavioral health services for CalOptima Health members; increased funding for contracted providers; increased staff oversight of OneCare provider directory.	**03/22/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
S. 1378 Cortez Masto (NV)	**S.1378 Connecting Our Medical Providers with Links to Expand Tailored and Effective (COMPLETE) Care Act:** Would improve access to timely, effective mental health care in the primary care setting by increasing Medicare payments to providers for implementing integrated care models. ***Potential CalOptima Health Impact**:* Increased resources and access to behavioral health services for CalOptima Health OneCare members; increased funding for contracted providers.	**04/27/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
SB 363 Eggman	**Behavioral Health Facilities Database:** No later than January 1, 2025, would require the California Department of Health Care Services (DHCS) to develop a real-time, internet-based database to display information about beds in certain facilities, including chemical dependency recovery hospitals, acute psychiatric hospitals and mental health rehabilitation centers, to identify the availability of inpatient and residential mental health or substance use disorder treatment. ***Potential CalOptima Health Impact:*** Increased resources and access to behavioral health services for CalOptima Health Medi-Cal members.	**05/18/2023** Passed Senate Appropriations Committee; referred to Senate floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 492 Pellerin	**Reproductive and Behavioral Health Integration Pilot Programs:** Would provide grants, incentive payments or other financial support to Medi-Cal managed care plans (MCPs) to partner with providers for the development and implementation of behavioral health integration pilot programs to improve access to services. Partnering providers must be enrolled in the Family Planning, Access, Care, and Treatment (Family PACT) program and provide reproductive health services. ***Potential CalOptima Health Impact:*** Increased funding and access to reproductive and behavioral health services.	**05/18/2023** Passed Assembly Appropriations Committee; referred to Assembly floor	CalOptima Health: Watch
AB 512 Waldron	**Behavioral Health Facilities Database:** Would require the California Health and Human Services Agency (CalHHS) to create a committee to study how to develop a real-time, internet-based system, usable by hospitals, clinics, law enforcement, paramedics and emergency medical technicians, and other health care providers to display information about available beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities and residential alcoholism or substance abuse treatment facilities in order to identify available facilities for the temporary treatment of individuals experiencing a mental health or substance use disorder crisis. ***Potential CalOptima Health Impact:*** Increased efficiency and timeliness of facility referrals; decreased visits to the emergency department.	**03/29/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 940 Villapudua	**Eating Disorder Treatment**: Would expand the approved facilities for inpatient treatment of eating disorders to include psychiatric health facilities. ***Potential CalOptima Health Impact:*** Increased access to treatment for eating disorders.	**04/11/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch
AB 1316 Irwin	**Psychiatric Emergency Medical Conditions**: Would require the Medi-Cal program to cover emergency services and care necessary to treat an emergency medical condition, including screening examinations necessary to determine the presence or absence of an emergency medical condition. ***Potential CalOptima Health Impact:*** Increased scope of behavioral health services for CalOptima Health Medi-Cal members.	**04/10/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1470 Quirk-Silva	**Behavioral Health Services: Documentation Standards:** Would require DHCS to develop standard forms, including intake and assessment forms, relating to the medical necessity criteria, mandatory screening and transition of care tools. No later than July 1, 2025, regional personnel training on documentation should be completed along with the exclusive use of the standard forms. ***Potential CalOptima Health Impact:*** Additional training for CalOptima Health behavioral health staff on new documentation and materials.	**05/18/2023** Passed Assembly Appropriations Committee; referred to Assembly floor	CalOptima Health: Watch
California Advancing and Innovating Medi-Cal (CalAIM)			
AB 586 Calderon	**Community Support: Climate Change Remediation:** Would add "climate change remediation" as a Community Support option, defined as the coverage and installation of devices to address health-related complications, barriers or other factors linked to extreme weather or other climate events, including air conditioners, heaters, air filters and generators. ***Potential CalOptima Health Impact:*** New services available for CalOptima Health Medi-Cal members.	**04/11/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 1338 Petrie-Norris	**Community Support: Fitness**: Would add fitness, physical activity, recreational sports, and mental wellness memberships as a Community Support option. ***Potential CalOptima Health Impact:*** New services available for CalOptima Health Medi-Cal members.	**04/18/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
Covered Benefits			
SB 257 Portantino	**Mammography:** Beginning January 1, 2025, would require health plans to cover, without cost sharing, screening mammography and medically necessary diagnostic breast imaging, including following an abnormal mammography result and for individuals with a risk factor associated with breast cancer. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**05/18/2024** Passed Senate Appropriations Committee; referred to Senate floor	CalOptima Health: Watch CAHP: Oppose
SB 324 Limón	**Endometriosis:** Would add any clinically indicated treatment for endometriosis as a covered benefit without prior authorization or other utilization review. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**05/18/2023** Passed Senate Appropriations Committee; referred to Senate floor	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 339 Wiener	**HIV Preexposure Prophylaxis and Postexposure Prophylaxis:** Would require the Medi-Cal program to cover preexposure prophylaxis and postexposure prophylaxis furnished by a pharmacist for up to a 90-day course. ***Potential CalOptima Health Impact:*** Expanded Medi-Cal Rx benefit for CalOptima Health Medi-Cal members.	**05/18/2023** Passed Senate Appropriations Committee; referred to Senate floor	CalOptima Health: Watch CAHP: Oppose Unless Amended
SB 496 Limón	**Biomarker Testing:** No later than July 1, 2024, would add biomarker testing, including whole genome sequencing, as a covered Medi-Cal benefit for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition to guide treatment decisions, if the test is supported by medical and scientific evidence. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**05/18/2023** Passed Senate Appropriations Committee; referred to Senate floor	CalOptima Health: Watch CAHP: Oppose Unless Amended
SB 694 Eggman	**Self-Measured Blood Pressure (SMBP) Devices and Services**: Would add SMBP devices and related services as covered Medi-Cal benefits for the treatment of high blood pressure. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**05/18/2023** Passed Senate Appropriations Committee; referred to Senate floor	CalOptima Health: Watch CalPACE: Support
AB 47 Boerner Horvath	**Pelvic Floor Physical Therapy**: Beginning January 1, 2024, would require health plans to provide coverage for pelvic floor physical therapy after pregnancy. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health Medi-Cal members.	**04/20/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch CAHP: Oppose
AB 365 Aguiar-Curry	**Continuous Glucose Monitors (CGMs):** Would add CGMs and related supplies as a covered Medi-Cal benefit, subject to utilization controls based on clinical practice guidelines. Would also authorize DHCS to require a manufacturer of CGMs to enter into a rebate agreement with DHCS. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**05/18/2023** Passed Assembly Appropriations Committee; referred to Assembly floor	CalOptima Health: Watch CalPACE: Support
AB 425 Alvarez	**Pharmacogenomics Advancing Total Health for All Act:** Would add pharmacogenomic testing as a covered Medi-Cal benefit, defined as laboratory genetic testing to identify how an individual's genetics may impact the efficacy, toxicity and safety of medications. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health Medi-Cal members.	**05/18/2023** Passed Assembly Appropriations Committee; referred to Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 608 Schiavo	**Perinatal Services**: Would require DHCS to cover additional perinatal assessments, individualized care plans, visits and units of services during the one-year postpartum Medi-Cal eligibility period that are at least proportional to those available during pregnancy and the initial 60-day postpartum period. DHCS would be required to collaborate with the California Department of Public Health and stakeholders to determine the specific levels of additional coverage. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**05/18/2023** Passed Assembly Appropriations Committee; referred to Assembly floor	CalOptima Health: Watch
AB 620 Connolly	**Digestive and Metabolic Disorders:** Beginning January 1, 2024, would require health plans to expand coverage for the testing and treatment of phenylketonuria (PKU) to include other digestive and inherited metabolic disorders. Coverage would include the formulas and special food products that are part of a prescribed diet. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**05/18/2023** Passed Assembly Appropriations Committee; referred to Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 847 Rivas, L.	**Pediatric Palliative Care Services**: Would extend Medi-Cal coverage for palliative care and hospice services, including concurrently, after 21 years of age for individuals who were previously determined eligible prior to 21 years of age. Would require Medi-Cal MCPs to be liable for payment of out-of-county services if unavailable in county of residence. ***Potential CalOptima Health Impact:*** Expanded covered benefit for certain CalOptima Health Medi-Cal members; increased costs for out-of-county services.	**05/18/2023** Passed Assembly Appropriations Committee; referred to Assembly floor	CalOptima Health: Watch
AB 907 Lowenthal	**PANDAS and PANS**: Beginning January 1, 2024, would require a health plan to provide coverage for treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) prescribed or ordered by a provider. ***Potential CalOptima Health Impact:*** New covered benefit for pediatric CalOptima Health Medi-Cal members.	**05/18/2023** Passed Assembly Appropriations Committee; referred to Assembly floor	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1036 Bryan	**Emergency Medical Transportation:** Would require a physician to certify upon patient arrival at an emergency room via emergency medical transportation whether an emergency medical condition existed and required emergency medical transportation. If certified, would require a health plan to provide coverage for emergency medical transportation. ***Potential CalOptima Health Impact:*** Increased CalOptima Health costs for reimbursement of emergency transportation services.	**04/18/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch
AB 1060 Ortega	**Naloxone Hydrochloride:** Would add prescription and non-prescription naloxone hydrochloride as a covered benefit under the Medi-Cal program for the treatment of an opioid overdose. ***Potential CalOptima Health Impact:*** New Medi-Cal Rx benefit for CalOptima Health Medi-Cal members.	**05/18/2023** Passed Assembly Appropriations Committee; referred to Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 1085 Maienschein	**Housing Support Services**: Would require DHCS to add housing support services as a covered Medi-Cal benefit for individuals experiencing or at risk of homelessness, consistent with the following Community Supports offered through CalAIM: • Housing Transition Navigation Services • Housing Deposits • Housing Tenancy and Sustaining Services ***Potential CalOptima Health Impact:*** Formalization of certain Community Support services as covered benefits for eligible CalOptima Health Medi-Cal members.	**05/18/2023** Passed Assembly Appropriations Committee; referred to Assembly floor	CalOptima Health: Watch CalPACE: Support
AB 1644 Bonta	**Medically Supportive Food**: Would add medically supportive food and nutrition intervention plans as covered Medi-Cal benefits, when determined to be medically necessary to a patient's medical condition by a provider or plan. The benefit would be based in part on the following Community Support offered through CalAIM: Medically Tailored Meals. ***Potential CalOptima Health Impact:*** Formalization and expansion of certain Community Support services as covered benefits for eligible CalOptima Health Medi-Cal members.	**04/25/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Eligibility and Enrollment			
S. 423 Van Hollen (MD) **H.R. 1113** Bera (CA)	**Easy Enrollment in Health Care Act:** To streamline and increase enrollment into public health insurance programs, would allow taxpayers to request their federal income tax returns include a determination of eligibility for Medicaid, the Children's Health Insurance Program (CHIP) or advance premium tax credits to purchase insurance through a health plan exchange. Taxpayers could also consent to be automatically enrolled into any such program or plan if they were subject to a zero net premium. Would also make individuals eligible for Medicaid or CHIP based on a prior finding of eligibility for the Temporary Assistance for Needy Families program or the Supplemental Nutrition Assistance Program. ***Potential CalOptima Health Impact*:** Expanded eligibility standards and procedures for enrollment of CalOptima Health members.	**02/14/2023** Introduced; referred to committees	CalOptima Health: Watch
SB 299 Eggman	**Medi-Cal Redeterminations:** Would remove the current requirement for a county to send a notice of action terminating Medi-Cal eligibility if the prepopulated redetermination form is returned as undeliverable and the purpose for the redetermination is loss of contact with the beneficiary. ***Potential CalOptima Health Impact:*** Reduced disenrollments of CalOptima Health members.	**05/18/2023** Passed Senate Appropriations Committee; referred to Senate floor	CalOptima Health: Watch
AB 1481 Boerner Horvath	**Medi-Cal Presumptive Eligibility for Pregnancy**: Would expand presumptive eligibility for pregnant women to all pregnant people, renaming the program "Presumptive Eligibility for Pregnant People" (PE4PP). Would make a presumptively eligible pregnant person eligible for all covered Medi-Cal benefits, except for inpatient services and institutional long-term care. If an application for full-scope Medi-Cal benefits is submitted within 60 days of a PE4PP determination, PE4PP coverage would be effective until the Medi-Cal application is approved or denied. ***Potential CalOptima Health Impact:*** Improved Medi-Cal enrollment process and timelier access to covered benefits for eligible pregnant individuals.	**05/18/2023** Passed Assembly Appropriations Committee; referred to Assembly floor	CalOptima Health: Watch
AB 1608 Patterson	**Regional Center Clients:** Would exempt from mandatory Medi-Cal MCP enrollment any dual-eligible and non-dual-eligible Medi-Cal beneficiaries who receive services from a regional center and use the Medi-Cal fee-for-service (FFS) delivery system as secondary form of health coverage. ***Potential CalOptima Health Impact:*** Decreased number of CalOptima Health members.	**03/27/2023** Amended and re-referred to Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Operations and Administration			
H.R.2811 Arrington (TX)	**Limit, Save, Grow Act of 2023:** Would require Medicaid beneficiaries ages 19–55 without dependents to work, complete community service, and/or participate in a work training program for at least 80 hours per month for at least three months per year. Exemptions would be provided for those who are pregnant, physically or mentally unfit for employment, complying with work requirements under a different federal program, participating in a drug or alcohol treatment program, or enrolled in school at least half-time. The U.S. Department of Health and Human Services estimates that 294,981 Medi-Cal beneficiaries in Orange County would be subject to the proposed work requirements without an exemption. ***Potential CalOptima Health Impact:*** Disenrollment of certain CalOptima Health Medi-Cal members, especially those who experience homelessness, who are not exempted from work requirements.	**04/26/2023** Passed House floor; referred to Senate Budget Committee	CalOptima Health: Concerns ACAP: Oppose
AB 557 Hart	**Brown Act Flexibilities:** Would permanently extend current Brown Act teleconferencing flexibilities — when a declared state of emergency is in effect — beyond January 1, 2024. Would also extend the period for a legislative body to make findings related to a continuing state of emergency from every 30 days to every 45 days. ***Potential CalOptima Health Impact:*** Extended teleconferencing flexibilities for Board and advisory committee meetings.	**05/15/2023** Passed Assembly floor; referred to Senate	CalOptima Health: Watch
AB 719 Boerner Horvath	**Public Transit Contracts**: Would require Medi-Cal managed care plans to contract with public transit operators for nonmedical transportation (NMT) and nonemergency medical transportation (NEMT) services. Would require reimbursement to be based on the Medi-Cal FFS rates for those services. ***Potential CalOptima Health Impact:*** Execution of additional NMT and NEMT contracts; increased transportation options for CalOptima Health Medi-Cal members.	**05/18/2023** Passed Assembly Appropriations Committee; referred to Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 1202 Lackey	**Pediatric Time and Distance Standards:** Would require Medi-Cal MCPs to report to DHCS the results of an analysis to identify the number and geographic distribution of Medi-Cal providers needed to ensure compliance with time and distances standards for pediatric primary care. ***Potential CalOptima Health Impact:*** Increased network analysis and reporting to DHCS.	**05/18/2023** Passed Assembly Appropriations Committee; referred to Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1690 Kalra	**Universal Health Care Coverage**: States the intent of the Legislature to guarantee accessible, affordable, equitable, and high-quality health care for all Californians through a comprehensive universal single-payer health care program. ***Potential CalOptima Health Impact:*** Unknown but potentially significant impacts to the Medi-Cal program and CalOptima Health care delivery, financing and administration.	**02/17/2023** Introduced	CalOptima Health: Watch
Older Adult Services			
S. 1002 Cassidy (LA)	**No Unreasonable Payments, Coding, or Diagnoses for the Elderly (No UPCODE) Act:** Would modify the MA risk adjustment model to prevent overpayment to MA plans, as follows: • Utilization of two years instead of one of diagnostic data • Exclusion of outdated diagnoses solely included on health risk assessments • Coding adjustment to account for other payment differences between MA and Medicare FFS ***Potential CalOptima Health Impact:*** Decreased reimbursement rates from the Centers for Medicare and Medicaid Services (CMS) for CalOptima Health OneCare members.	**03/28/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
SB 311 Eggman	**Medicare Part A Buy-In:** No later than January 1, 2024, would require DHCS to submit a Medicaid state plan amendment to enter into a Medicare Part A buy-in agreement with CMS. This would allow DHCS to automatically enroll individuals with a Part A premium into Part A on their behalf. ***Potential CalOptima Health Impact:*** Simplified Medicare enrollment and increased financial stability for dual-eligible CalOptima Health members with Part A premium requirements.	**05/18/2023** Passed Senate Appropriations Committee; referred to Senate floor	CalOptima Health: Watch LHPC: Support CalPACE: Support
AB 1022 Mathis	**Program of All-Inclusive Care for the Elderly (PACE) Rates and Assessments**: Would require PACE capitation rates to also reflect the frailty level and risk associated with participants. In addition, would expand a PACE organization's authority to use video telehealth to conduct all assessments. ***Potential CalOptima Health Impact:*** Increased capitation rates for CalOptima Health PACE participants; expanded use of video telehealth assessments.	**03/02/2023** Referred to Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1223 Hoover	**PACE Audits:** Would require DHCS to perform program audits of PACE organizations and to develop and maintain standards, rules, and auditing protocols, including related to data collection, technical assistance, formal decisions and enforcement of non-compliance. ***Potential CalOptima Health Impact:*** Modified audit protocols for CalOptima Health PACE.	**03/13/2023** Amended and re-referred to Assembly Health Committee	CalOptima Health: Watch
AB 1230 Valencia	**Special Needs Plans (SNPs)**: No later than January 1, 2025, would require DHCS to offer contracts to health plans for Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) to provide care to dual eligible beneficiaries. ***Potential CalOptima Health Impact:*** Increased number of SNPs in Orange County; decreased number of CalOptima Health OneCare members.	**04/20/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch LHPC: Oppose
Providers			
H.R. 497 Duncan (SC)	**Freedom for Health Care Workers Act:** would repeal the rule issued by CMS on November 5, 2021, that requires health care providers participating in the Medicare and Medicaid programs to ensure staff are fully vaccinated against COVID-19**.** ***Potential CalOptima Health Impact:*** Elimination of COVID-19 vaccination mandate for CalOptima Health PACE staff and contracted providers.	**01/31/2023** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch
SB 598 Skinner	**Prior Authorization "Gold Carding"**: Beginning January 1, 2025, would prohibit a health plan from requiring a contracted provider to obtain a prior authorization for any services if the plan approved or would have approved no less than 90% of the prior authorization requests submitted by the provider in the most recent one-year contracted period. ***Potential CalOptima Health Impact:*** Implementation of new utilization management (UM) procedures to assess provider approval rates; decreased number of prior authorizations.	**05/18/2023** Passed Senate Appropriations Committee; referred to Senate floor	CalOptima Health: Watch CAHP: Oppose
SB 819 Eggman	**Medi-Cal Mobile Health Care Site Enrollment:** Would exempt intermittent or mobile health care sites from enrolling in Medi-Cal as a separate provider if operated by a government-operated primary care clinic that is exempt from licensure by the California Department of Public Health. ***Potential CalOptima Health Impact:*** Expansion of intermittent and mobile health care sites; increased access to care for CalOptima Health members.	**05/11/23** Referred to Assembly Health Committee **05/04/2023** Passed Senate floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 236 Holden	**Provider Directory Audits:** Would require health plans to annually audit and delete inaccurate listings from its provider directories. Would also require a provider directory to be 60% accurate by January 1, 2024, with increasing percentage accuracy each year until the directories are 95% accurate by January 1, 2027. In addition, plans would be subject to penalties for failure to meet the prescribed benchmarks and for each inaccurate listing in its directories. Finally, beginning July 1, 2024, would require plans to delete a provider from its directory if a plan has not reimbursed the provider in the prior year. ***Potential CalOptima Health Impact:*** Increased oversight of CalOptima Health provider directory; increased coordination with contracted providers; increased penalty payments to DHCS.	**03/14/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
AB 564 Villapudua	**Medi-Cal Claim Signatures**: Would allow Medi-Cal providers to submit electronic signatures for claims and remittance forms. ***Potential CalOptima Health Impact:*** Reduced administrative burden for CalOptima Health contracted providers.	**05/18/2023** Passed Assembly Appropriations Committee; referred to Assembly floor	CalOptima Health: Watch
AB 815 Wood	**Provider Credentials**: Would require CalHHS to create a provider credentialing board that certifies entities to credential providers in lieu of a health plan's credentialing process, effective July 1, 2025. Would require a health plan to accept a credential from such entities without imposing additional criteria and to pay a fee to such entities based on the number of contracted providers credentialed. Health plans could use their own credentialing processes for any providers who are not credentialed by certified entities. ***Potential CalOptima Health Impact***: Reduced credentialing application workload for CalOptima Health staff; reduced quality oversight of contracted providers.	**05/18/2023** Passed Assembly Appropriations Committee; referred to Assembly floor	CalOptima Health: Watch CAHP: Concerns
AB 904 Calderon	**Doula Access**: Beginning January 1, 2025, would require a health plan to develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas. ***Potential CalOptima Health Impact:*** Increased access to prenatal care for eligible CalOptima Health Medi-Cal members; additional provider contracting and credentialing, additional staff time for program management.	**05/18/2023** Passed Assembly Appropriations Committee; referred to Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 931 Irwin	**Physical Therapy Prior Authorization**: Beginning January 1, 2025, would prohibit health plans from requiring prior authorization for the initial 12 treatment visits for a new episode of care for physical therapy. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**05/10/23** Referred to Senate Health Committee **05/01/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 1122 Bains	**Medi-Cal Provider Applications:** Would allow providers to submit any primary source documentation as proof of information required on a Medi-Cal enrollment application. Would also authorize providers to submit applications up to 30 days before having an established place of business. ***Potential CalOptima Health Impact:*** Streamlined Medi-Cal provider enrollment process; increased number of CalOptima Health contracted providers.	**04/18/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 1241 Weber	**Medi-Cal Telehealth Access:** Would require Medi-Cal telehealth providers to maintain the ability to either offer in-person services or arrange a referral to in-person services. However, this would not require a provider to schedule an appointment with a different provider on behalf of a patient. ***Potential CalOptima Health Impact:*** Continued flexibility to access in-person, video, and audio-only health care services for CalOptima Health Medi-Cal members.	**05/18/2023** Passed Assembly Appropriations Committee; referred to Assembly floor	CalOptima Health: Watch
AB 1288 Reyes	**Medication-Assisted Treatment Prior Authorization**: Would prohibit health plans from requiring prior authorization for a buprenorphine product, methadone, or long-acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder, when prescribed according to generally accepted national professional guidelines. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**05/18/2023** Passed Assembly floor; referred to Senate	CalOptima Health: Watch CAHP: Oppose
Rates & Financing			
S. 570 Cardin (MD) **H.R. 1342** Barragan (CA)	**Medicaid Dental Benefit Act of 2023:** Would require state Medicaid programs to cover dental and oral health services for adults. Would also increase the Federal Medical Assistance Percentage (FMAP) (i.e., federal matching rate) for such services. CMS would be required to develop oral health quality and equity measures and conduct outreach relating to dental and oral health coverage. ***Potential CalOptima Health Impact:*** Increased payments to CalOptima Health and contracted providers; additional quality metrics.	**02/28/2023** Introduced; referred to committees	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 485 McMorris (WA)	**Protecting Health Care for All Patients Act of 2023:** Would prohibit all federally funded health care programs from using quality-adjusted life years (i.e., measures that discount the value of a life based on disability) to determine coverage and payment determinations for treatments and prescription drugs. ***Potential CalOptima Health Impact:*** Modified authorization limits for certain CalOptima Health members.	**03/23/2023** Passed by House Energy and Commerce Committee; referred to House floor	CalOptima Health: Watch
SB 282 Eggman	**Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Same-Day Visits**: Would authorize reimbursement for a maximum of two separate visits that take place on the same day at a single FQHC or RHC site, whether through a face-to-face or telehealth-based encounter (e.g., a medical visit and dental visit on the same day). In addition, would add a licensed acupuncturist within those health care professionals covered under the definition of a "visit." ***Potential CalOptima Health Impact:*** Timelier access to services at CalOptima Health's contracted FQHCs.	**05/18/2023** Passed Senate Appropriations Committee; referred to Senate floor	CalOptima Health: Watch LHPC: Support
SB 340 Eggman	**Eyeglasses Reimbursement**: Would authorize a provider to purchase eyeglasses from a private entity instead of from the Prison Industry Authority for the purpose of Medi-Cal reimbursement for covered optometric services. ***Potential CalOptima Health Impact:*** Timelier access to prescription eyeglasses for CalOptima Health Medi-Cal members.	**05/18/2023** Passed Senate Appropriations Committee; referred to Senate floor	CalOptima Health: Watch
SB 870 Caballero	**Managed Care Organization (MCO) Tax:** Would renew the MCO tax on health plans, which expired on January 1, 2023, to an unspecified future date. Would also modify the tax rates to unspecified percentages that are based on the Medi-Cal membership of the health plan. ***Potential CalOptima Health Impact:*** Increased tax liability on CalOptima Health.	**04/26/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch
AB 55 Rodriguez	**Ground Ambulance Transportation**: Effective January 1, 2024, would require Medi-Cal MCPs to implement a value-based purchasing model that increases reimbursement to ground ambulance transportation providers who meet certain workforce standards. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health's contracted transportation providers; increased costs for CalOptima Health.	**04/25/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 488 Nguyen, S.	**Vision Loss:** Would modify the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program measures and milestones to include program access, staff training, and capital improvement measures aimed at addressing the needs of SNF residents with vision loss. ***Potential CalOptima Health Impact:*** Modified payments to CalOptima Health contracted SNFs; increased data collection, tracking and reporting requirements; improved quality of life for certain members with vision loss.	**03/27/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch
AB 576 Weber	**Abortion Reimbursement**: Would require DHCS to fully reimburse Medi-Cal providers for providing medication to terminate a pregnancy that aligns with clinical guidelines, evidence-based research and provider discretion. ***Potential CalOptima Health Impact:*** Increased financial stability for eligible CalOptima Health contracted providers.	**05/18/2023** Passed Assembly Appropriations Committee; referred to Assembly floor	CalOptima Health: Watch
AB 1549 Carrillo	**FQHC and RHC Rates:** Would require that DHCS's per-visit rates to FQHCs and RHCs account for costs that are reasonable and related to the provision of covered services, the intensity of activities taking place in an average visit, the length or duration of a visit and the number of activities provided during a visit. ***Potential CalOptima Health Impact:*** Increased financial stability of CalOptima Health's contracted FQHCs.	**04/25/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 1698 Wood	**Medi-Cal Funding**: States the intent of the Legislature to enact future legislation to increase overall funding and reimbursement for the Medi-Cal program. ***Potential CalOptima Health Impact***: Increased financial stability for CalOptima Health and its contracted providers.	**02/17/2023** Introduced	CalOptima Health: Watch
Social Determinants of Health (SDOH)			
H.R. 1066 Blunt Rochester (DE)	**Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants Act of 2023:** Would require CMS to update guidance at least once every three years to help states address SDOH under Medicaid and CHIP. ***Potential CalOptima Health Impact:*** Increased opportunities for CalOptima Health to address SDOH.	**02/17/2023** Introduced; referred to House Energy and Commerce Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 85 Weber	**SDOH Screenings:** Would add SDOH screenings as a covered Medi-Cal benefit. Would also require health plans to provide primary care providers with adequate access to community health workers, social workers and peer support specialists. Would also FQHCs and RHCs to be reimbursed for these services at the Med-Cal FFS rate. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**05/18/2023** Passed Assembly Appropriations Committee; referred to Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 257 Hoover	**Encampment Restrictions:** Would prohibit a person from sitting, lying, sleeping or placing personal property in any street, sidewalk or other public property within 500 feet of a school, daycare center, park or library. ***Potential CalOptima Health Impact:*** Increased outreach and support services for unsheltered CalOptima Health Medi-Cal members.	**03/07/2023** Failed passage in Assembly Public Safety Committee	CalOptima Health: Watch
AB 271 Quirk-Silva	**Homeless Death Review Committee:** Would authorize counties to establish a homeless death review committee for the purpose of gathering information to identify the root causes of the deaths of homeless individuals and to determine strategies to improve coordination of services for the homeless population. ***Potential CalOptima Health Impact:*** Increased coordination and data review between the County of Orange and CalOptima Health.	**05/03/2023** Referred to Senate Public Safety Committee and Senate Human Services Committee **03/06/2023** Passed Assembly floor	**03/02/2023** CalOptima Health: Support

Information in this document is subject to change as bills proceed through the legislative process.

ACAP: Association for Community Affiliated Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: May 18, 2023

2023 Federal Legislative Dates

January 3	118th Congress, 1st Session convenes
July 31–September 4	Summer recess for Senate
July 31–September 11	Summer recess for House
December 15	1st Session adjourns

Source: Floor Calendars, United States Congress: https://www.congress.gov/calendars-and-schedules

2023 State Legislative Dates

January 4	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
February 17	Last day for legislation to be introduced
March 30–April 10	Spring recess
April 28	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house
May 5	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house
May 19	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house
May 30–June 2	Floor session only
June 2	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 14	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 14–August 14	Summer recess
September 1	Last day for fiscal committees to report bills in their second house to the Floor
September 5–14	Floor session only
September 8	Last day to amend bills on the Floor
September 14	Last day for each house to pass bills; final recess begins upon adjournment
October 14	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2023 State 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 — May and June 2023

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 as well as supports our community partners' public activities.

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

We continue to participate in public activities virtually in most instances, with limited in-person attendance. Participation includes providing Medi-Cal educational materials and, if criteria are met, financial support and/or CalOptima Health-branded items.

Community Outreach Highlight

CalOptima Health is continuing outreach efforts to inform our members and community about the Medi-Cal renewal process and ensure our members keep their healthcare benefits. We're collaborating with the Orange County Social Services Agency (SSA) and Covered California to develop video recordings in English, Spanish and Vietnamese. The videos will be shared via text and at caloptima.org/renew in mid-May. CalOptima Health and SSA will also be hosting a Medi-Cal Redetermination and CalFresh Enrollment Event on June 10, 9 a.m.–1 p.m., at St. Anthony Claret Catholic Church in Anaheim. SSA will be on-site to provide Medi-Cal renewal support as well as CalFresh and Medi-Cal enrollment services. The event will feature a community resource fair, with food and diaper distribution and family-friendly activities.

Summary of Public Activities

As of May 22, CalOptima Health plans to participate in, organize or convene 104 public activities in May and June. In May, there will be 70 public activities, including 35 virtual community/collaborative meetings, nine community-based presentations, 25 community events and one Health Network Forum. In June there will be 34 public activities, including 20 virtual community/collaborative meetings, two community-based presentations, nine community events, one Health Network Forum and one Cafecito meeting. 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 (e.g., 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. Use of CalOptima Health's name and logo for Latino Health Access for the Community Health Worker and Promotor Workforce Capacity Building Collaborative.

2. Letter of Support to Vista Community Clinic's application to provide Program of All-Inclusive Care for the Elderly (PACE) services in portions of Los Angeles County.

3. Letter of Support for Share Our Selves' application for a Health Resources and Services Administration grant to support School-Based Health Center with Newport Mesa Unified School District.

For additional information or questions, contact CalOptima Health Community Relations Director Tiffany Kaaiakamanu at 657-235-6872 or tkaaiakamanu@caloptima.org.

Attachment to the June 1, 2023, CalOptima Health Outreach Summary

Community events hosted by CalOptima Health and community partners in May and June 2023:

May 2023

May 1, 1:30–4 p.m., Student Wellness Resource Fair, hosted by California State University, Fullerton (CSUF)

Fullerton College, 321 E. Chapman Ave., Fullerton

- At least one staff member attended (in-person).
- Health/resource fair, open to the public

May 3, 11 a.m.–Noon, CalOptima Health Medi-Cal Overview in English

Boat People SOS Center for Community Advancement, Virtual

- At least one staff member presented.
- Community-based organization presentation, open to collaborative members

May 3, 9–10 a.m., CalOptima Health Medi-Cal Overview in English

HIRE OC, Virtual

- At least one staff member presented.
- Community-based organization presentation, open to collaborative members

May 3, 2–3 p.m., CalOptima Health Overview Presentation in English

World Relief, Virtual

- At least one staff member presented.
- Community-based organization presentation, open to collaborative members

May 4, Noon–3 p.m., Resource Fair, hosted by Jamboree

2691 W. La Palma Ave., Anaheim

- At least two staff members attended (in-person).
- Health/resource fair, open to the public

May 4, 5–6 p.m., Choose Wellness Resource Fair, hosted by Garden Grove Unified School District (GGUSD)

9401 Westminster Blvd., Garden Grove

- At least two staff members attended (in-person).
- Health/resource fair, open to the public

May 4, Distribution of CalFresh Fliers Friendly Center

6688 Beach Blvd., Buena Park

- At least one staff member participated.
- Mailed CalFresh materials.

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

May 5, 10:30–11:30 a.m., Meeting with Jamboree Housing
8180 Commonwealth Ave., Buena Park

- At least one staff member attended (in-person).
- Meeting to share information about Medi-Cal and CalFresh

May 5, 8 a.m.–5 p.m., Meeting of the Minds Mental Health Conference, hosted by the Mental Health Association of Orange County (MHA)
Anaheim Marriott, 700 W. Convention Way, Anaheim

- At least nine staff members attended (in-person).
- Sponsorship fee: $2,500; included being featured as supporting sponsor in event program and in all media at the event's resource table; acknowledgement on front cover of program and half-page inside as well as on MHA's website through 2023; and admission for eight.
- Forum, open to the public

May 5, 5–7:30 p.m., Community Fair, hosted by Fullerton School District (FSD)
Gilbert Park, 2120 W. Orangethorpe Ave., Fullerton

- At least one staff member attended (in-person).
- Health/resource fair, open to the public

May 6, 10 a.m.–1 p.m., Children's Day Health Fair, hosted by OC Supervisor Doug Chaffee
Brookhurst Park, 2271 Crescent Ave., Anaheim

- At least two staff members attended (in-person).
- Health/resource fair, open to the public

May 7, 10 a.m.–2 p.m., Health Fair, hosted by Vietnamese Community Health
University of California, Los Angeles (UCLA), 14140 All American Way, Westminster

- At least one staff member attended (in-person).
- Health/resource fair, open to the public

May 8, 6–7:15 p.m., Mental Health Presentation, hosted by Placentia Yorba Linda Unified School District (PYLUSD)
161 E La Jolla St., Placentia

- At least one staff member attended (in-person).
- Health/resource fair, open to the public

May 9–11, 9 a.m.–1:30 p.m., Health Literacy Virtual Conference, hosted by the Institute for Healthcare Advancement (IHA)
Virtual

- Sponsorship fee: $750; included live commercials, banner ad, logo placement on emails and sponsor page, and attendance for two representatives.
- Forum, open to the public

May 10, 5:30–6:30 p.m., CalOptima Health Medi-Cal Overview in English
Jamboree Housing, 4000 El Camino Real, Irvine

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

- At least one staff member presented (in-person).
- Community-based organization presentation; open to members/community

May 10, Noon–1 p.m., Meeting with Huntington Beach Adult School

Virtual

- At least two staff members attended.
- Meeting to share information about Medi-Cal and CalFresh.

May 11, 11:30 a.m.–12:30 p.m., CalOptima Health Medi-Cal Overview in English

City of Huntington Beach Homeless and Behavioral Health Services, 2000 Main Way, Huntington Beach

- At least two staff members presented (in-person).
- Community-based organization presentation, open to collaborative members

May 11, Distribution of CalFresh Fliers to Cypress College

9200 Valley View St., Cypress

- At least one staff member participated.
- Mailed CalFresh materials.

May 11, 4:30–6:30 p.m., Westmont Open House, hosted by Westmont Elementary School

1525 W Westmont Dr., Anaheim

- At least two staff members attended (in-person).
- Health/resource fair, open to the public

May 12, 9 a.m.–Noon, General Assembly Resource Fair, hosted by the Santa Ana Early Learning Initiative (SAELI)

Delhi Center, 505 E. Central Ave., Santa Ana

- At least one staff member attended (in-person).
- Health/resource fair, open to the public

May 12, 2–6 p.m., May Your Mental Health Thrive with H.O.P.E., hosted by Abrazar

505 E Central Ave., Santa Ana

- At least two staff members attended (in-person).
- Health/resource fair, open to the public

May 13, 9 a.m.–1 p.m., Caregiver Recognition Day, hosted by Alzheimer's Orange County (AlzOC)

South Coast Global Medical Center, 2701 S. Bristol St., Santa Ana

- At least one staff member attended (in-person).
- Sponsorship fee: $300; included resource table at event, welcome presentation to participants, logo placement at the event and in the event agenda as well as in program information in goody bags, breakfast for two, and certificate of recognition.
- Health/resource fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

May 14, 2–3 p.m., Meeting with UCI Women's Center
505 E Central Ave., Santa Ana

- One staff member participated.
- Meeting to share information about Medi-Cal and CalFresh

May 17, 8 a.m.–4 p.m., 2023 FaCT Annual Conference, hosted by Families and Communities Together (FaCT)
Great Wolf Lodge, 12681 Harbor Blvd., Garden Grove

- At least eight staff members attended (in-person).
- Sponsorship fee: $3,020; included logo on promotional materials, recognition PowerPoint, video at the conference, resource table at event, mention on the conference landing page, and four event tickets.
- Community-based organization presentation, open to members/community

May 17, 5:30–7:30 p.m., Open House, hosted by Agnes Ware Stanley Elementary School
12201 Elmwood St., Garden Grove

- At least two staff members attended (in-person).
- Health/resource fair, open to the public

May 18, 9 a.m.–Noon, Spring Together: An Older Adult Mental Health Fair, hosted by Multi-Ethnic Collaborative of Community Agencies (MECCA)
505 E. Central Ave., Santa Ana

- At least one staff member attended (in-person).
- Health/resource fair, open to the public

May 18, 9 a.m.–6 p.m., Road to Accelerate: Medicaid Mastery Event, hosted by Applied General Agency
901 Via San Clemente, Montebello

- At least two staff members attended (in-person).
- Forum, open to the public

May 18, 11 a.m.–Noon, CalOptima Health Medi-Cal Overview in English
Jamboree Housing, 8180 Commonwealth Ave., Buena Park

- At least one staff member presented (in-person).
- Community-based organization presentation, open to members/community

May 18, 5–7 p.m., Community Resource Fair, hosted by Santa Ana Unified School District (SAUSD) Community Advisory Committee
2802 S. Flower St., Santa Ana

- At least one staff member attended (in-person).
- Health/resource fair, open to the public

May 19, 9:30–10:30 a.m., Meeting with Catholic Charities
Jamboree Housing, 8180 Commonwealth Ave., Buena Park

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

- One staff member participated.
- Meeting to share information about Medi-Cal and CalFresh

May 19, 9 a.m.–Noon, Ma(n)y Celebration, hosted by Asian American Senior Citizens Service Center

3101 W Harvard St., Santa Ana

- At least one staff member attended (in-person).
- Health/resource fair, open to the public

May 19, 10 a.m.–2 p.m., Boat People SOS Center for Community Advancement Textbook Pickup Day/Pre-Testing

- At least one staff member attended (in-person).
- Health/resource fair, open to the members/community

May 19, 1–2 p.m., WIC/CalFresh Planning Meeting with First 5 OC

3101 W Harvard St., Santa Ana

- At least one staff member participated.
- Meeting to discuss CalFresh and WIC efforts

May 19, 4–5 p.m., CalOptima Health Medi-Cal Overview Presentation in English with Mandarin interpreter

OC Chinese Community Center, Virtual

- At least one staff member presented.
- Community-based organization presentation, open to members/community

May 20, 8:30 a.m.–Noon, Super Kids Health Expo, hosted by CHOC Wellness on Wheels

950 Highland St., Santa Ana

- At least one staff member attended (in-person).
- Health/resource fair, open to the public

May 20, 9 a.m.–Noon, Open House and Community Resource Fair, hosted by North Orange County Regional Occupational Program and Healthy Smiles for Kids of Orange County

Trident Education Center, 1800 W. Ball Rd., Anaheim

- At least one staff member attended (in-person).
- Health/resource fair, open to the public

May 20, 10 a.m.–1 p.m., Mental Health Awareness Community Resource Fair, hosted by Anaheim Elementary School District (AESD)

535 S. Walnut St, Anaheim

- At least one staff member attended (in-person).
- Health/resource fair, open to the public

May 20, 11 a.m.–Noon, Wellness at the Zoo, hosted by Olive Crest
1801 E. Chestnut Ave, Santa Ana
- At least two staff members attended (in-person).
- Health/resource fair, open to the public

May 23, 4:30–7:45 p.m., Parent Leadership Spring Conference, hosted by Westminster School District (WSD)
Stacey Middle School, 6311 Larchwood Dr., Huntington Beach
- At least one staff member attended (in-person).
- Health/resource fair, open to the public

May 25, 10:30–11:30 a.m., CalOptima Health Medi-Cal Overview in English
Radiant Futures, Virtual
- At least one staff member presented.
- Community-based organization presentation, open to members/community

May 31, 10 a.m.–1 p.m., CalOptima Health Medi-Cal Overview in Spanish
Wesley Village, 10861 Acacia Pkwy., Garden Grove
- At least one staff member presented (in-person).
- Community-based organization presentation, open to members/community

June 2023

June 5, 1–3 p.m., Literacy and Wellness Event for Migrant Education Families, hosted by SAUSD
1601 E Chestnut Ave., Santa Ana
- At least one staff member to attend (in-person).
- Health/resource fair, open to the public.

June 10, 9 a.m.–1 p.m., Medi-Cal Renewal and CalFresh Enrollment Event
St. Anthony Claret Church, 1450 E. La Palma Ave., Anaheim
- At least nine staff members to attend (in-person).
- Health/resource fair, open to the public.

June 12, 9:30–10:30 a.m., CalOptima Health Medi-Cal Overview in Spanish
Whitten Community Center, 900 S. Melrose St., Placentia
- At least one staff member to attend (in-person).
- Community-based organization presentation, open to members/community

June 15, 10 a.m.–Noon, 2023 World Elder Abuse Awareness Day, hosted by the Orange County Aging Services Collaborative (OCASC)
Virtual
- At least two staff members to attend.
- Sponsorship fee: $2,500; includes logo on promotional materials, recognition on introduction reel, presentation slides, electronic event program and acknowledgement during welcome remarks.

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation
Exhibitor/Attendee

- Forum, open to the public

June 16, 8:30 a.m.–Noon, Senior Town Hall, hosted by Assemblymembers Diane Dixon and Laurie Davies

Laguna Hills Community Center 25555 Alicia Pkwy., Laguna Hills

- At least one staff member to attend (in-person).
- Health/resource fair, open to the public

June 17, 11 a.m.–6 p.m., Juneteenth, hosted by the Orange County Heritage Council (OCHC)

Centennial Park, 3000 Edinger Ave., Santa Ana

- At least two staff members to attend (in-person).
- Registration fee: $200; includes resource table at event.
- Health/resource fair, open to the public

June 17, 10 a.m.–3 p.m., Summer Learning Day, hosted by PBS Kids

The Children's Museum at La Habra, 301 S. Euclid St., La Habra

- At least two staff to attend (in-person).
- Health/resource fair, open to the public

June 24, 11 a.m.–4 p.m., OC Pride Festival, hosted by Orange County LGBTQIA Pride

253 E. Third St., Santa Ana

- At least two staff members to attend (in-person).
- Health/resource fair, open to the public

June 24, Noon–4 p.m., Health Fair, hosted by Hoag and Tustin Presbyterian Church

225 W. Main St., Tustin

- At least one staff member to attend (in-person).
- Health/resource fair, open to the public

June 24, Community Event, hosted by OC Supervisor Vincente Sarmiento

TBD

- At least two staff members to attend (in-person).
- Health/resource fair, open to the public

June 26, 10–11 a.m., CalOptima Health Medi-Cal Overview in English

Vital Access Care Foundation, 17150 New Hope St., Fountain Valley

- At least one staff member to present (in-person).
- Community-based organization presentation, open to members/community

June 27, 9–10:30 a.m., Cafecito Meeting

Virtual

- At least eight staff to attend.
- Steering committee meeting, open to collaborative members

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

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

Digital Transformation Updates

Board of Directors Meeting
June 2023

Wael Younan, Chief Information 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.

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Digital Transformation

2023 Key Planned Milestones

- Complete
- In Process
- Planned

Q1	Q2	Q3	Q4
Completed In House Provider Portal Enhancements	Begin CRM Efforts	Begin Member Mobile App Implementation	Complete Initial RPA Implementation
Begin Member Portal and Internal Apps Modernization Implementation	Complete Migration of Member Portal and Internal Apps to Cloud	Begin Contact Center Telephony Implementation	Complete Web Content Management Implementation
Begin Lift and Shift Migration to Cloud Wave 1	Begin RPA to Capture Faxes as Data	Begin Financial Management Implementation	Complete Delphix Data Masking Pilot Implementation

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COBAR Approved Projects in Progress

Projects	Budget
Burgess Reimbursement System	$1,650,000
Robotic Process Automation	$1,500,000
Customer Relationship Management	$925,000
Web Traffic Analytic Solution	$150,000
FWA Data Analytics/Detection Solution	$950,000
Encounter Data Management System	$3,500,000
Data Protection and Recovery Solution	$450,000
Cybersecurity Asset Management	$400,000
Cloud Migration Strategy	$340,000
Enterprise Resource Planning System	$1,312,000
Web Content Management Platform	$750,000
Care Management System	$3,000,000
Member and Provider Engagement	$2,865,000
Redetermination Member Engagement	$250,000
Mobile Member App	$800,000
Privileged Access Management	$200,000
Modern Customer Contact Center	$2,250,000
Data Masking	$200,000
Capital Assets, Salary, Wages, Benefits, Other	$5,292,233
TOTAL	**$26,784,233**

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CalOptima Health

2023-2024 Fiscal Year Digital Transformation:

Capital Project Type	FY 2023-24 Budget
Infrastructure (e.g., Network Bandwidth Upgrade, Internet Bandwidth Upgrade, Customer Service Virtual Agent Support)	$3,387,000
Applications Management (e.g., Customer Relationship Management System, Care Management System Enhancement, Healthcare Enterprise Management Platform)	$11,750,000
Enterprise Data and Systems Integration (e.g., Member Master Data Management, Data Warehouse Architecture Enhancement)	$1,550,000
Applications Development (e.g., Human Resources Capital Management Solution Software, Mobile Application Development Testing Tool)	$3,300,000
Enterprise Architecture (e.g., Provider Virtual Agent Support)	$1,000,000
Total:	**$20,987,000**

- 3/17/22: Board authorized a three-year strategy and created a $100 million restricted reserve to fund digital transformation efforts
- Proposed budget reflects capital projects during Year Two of implementation

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CalOptima Health

KEY SECURITY INITIATIVES

Zero Trust Initiatives

- Privilege Account Management (RFQ)
- Zero Trust Network Architecture (Zscaler)

Data Protection

- G Drive Cleanup
- Data Protection (Varonis)
- Data Masking (Delphix)
- Data Backup/Recovery Solution (RFQ)

Enhanced Security Operations

- NIST Cyber Security Framework Alignment
- Asset Management (RFQ)
- Security Operations Center
- Security Automation

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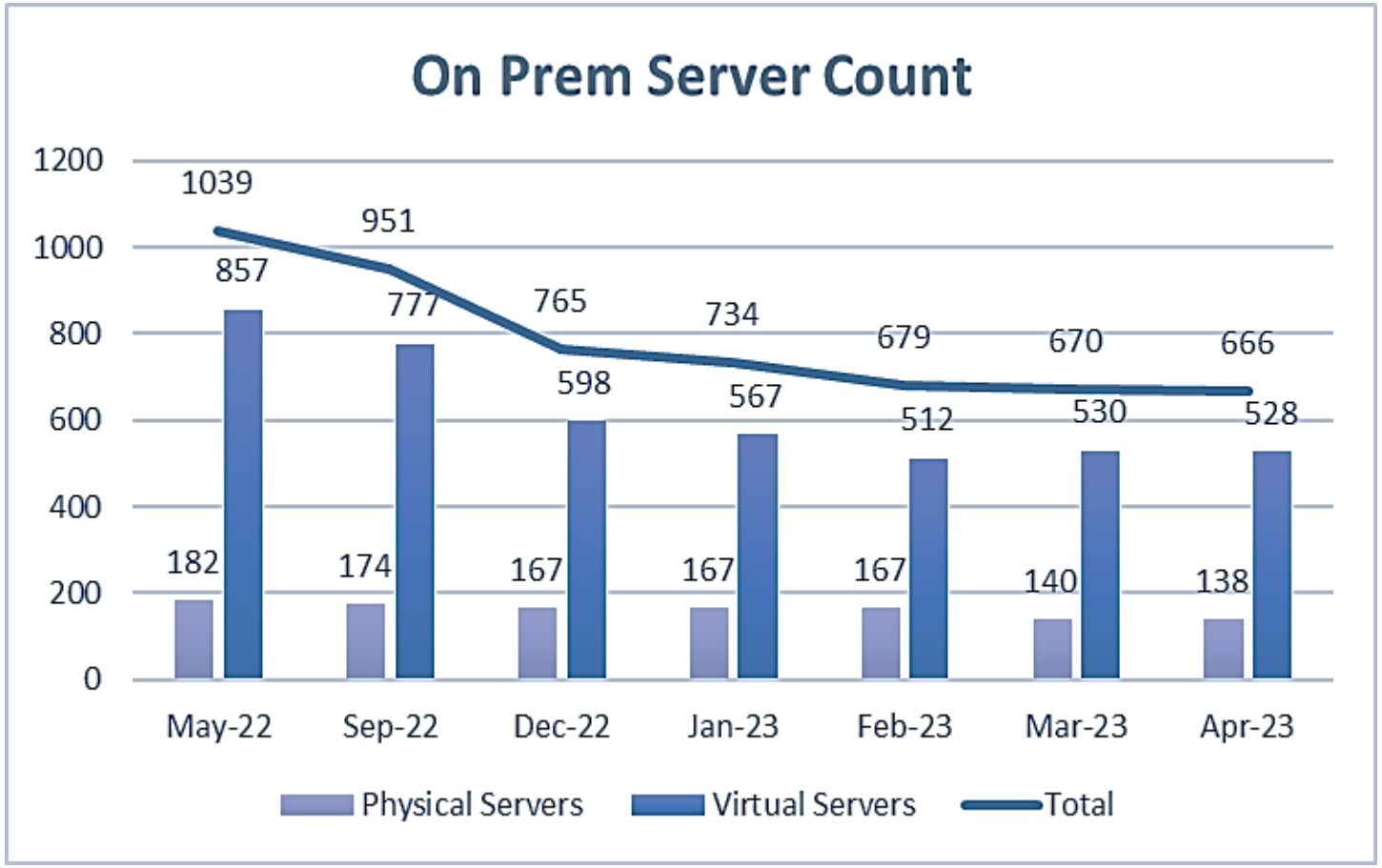
CalOptima Health

Server Reduction Progress



- Started initiative with 1039 servers, we are down to 666 servers
- 373 servers decommissioned
- 84 servers have moved to cloud
- Continue to find areas for further optimization

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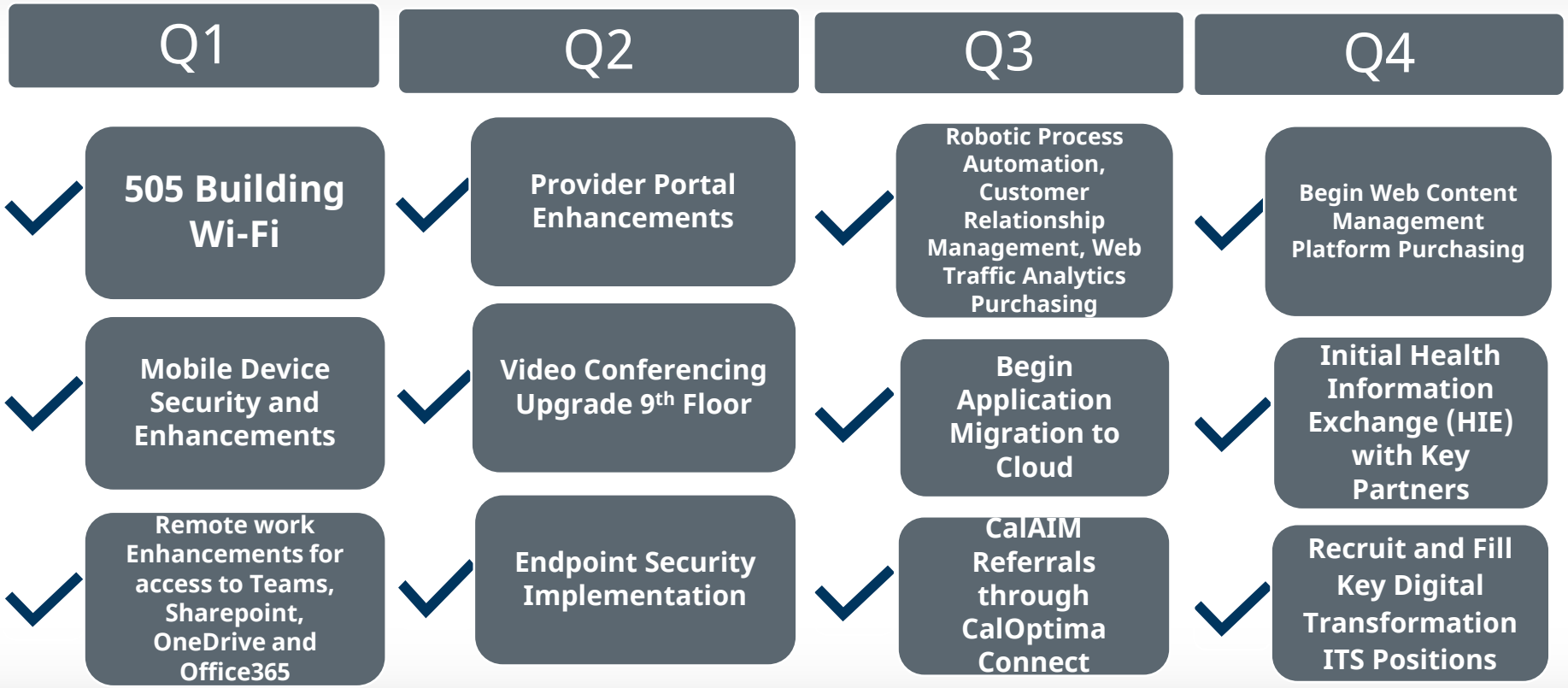
Appendix-Digital Transformation

✓ Complete

→ In Process

2022 Key Planned Milestones



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Deferred to the August 3, 2023 Board meeting

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
17. Election of Officers of the Board of Directors for Fiscal Year 2023-24

Contact
Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Action
Elect Board Chair and Vice Chair for terms effective July 1, 2023, through June 30, 2024, or until the election of a successor(s), unless the Board Chair or Vice Chair shall sooner resign or be removed from office.

Background/Discussion
In accordance with Article VIII, Section 8.1 of CalOptima Health's Bylaws, the Board shall elect one of its Directors as Chair at an organizational meeting. The Chair shall be the principal officer of the Board and shall preside at all meetings of the Board, shall appoint all members of the Ad Hoc Committees, as well as the chair of the Ad Hoc Committees and all Committees other than the Member and Provider Advisory Committees. The Chair shall perform all duties incident to the office and such other duties as may be prescribed by the Board from time to time.

Section 8.2 of the CalOptima Health Bylaws states that the Board shall elect one of its Directors to serve as Vice Chair at an organizational meeting. The Vice Chair shall perform the duties of the Chair if the Chair is absent from the meeting or is otherwise unable to act.

The Chair and Vice Chair terms shall commence on the first day of the month after the organizational meeting at which they are elected to their respective positions.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The recommended actions are in accordance with Article VIII of the CalOptima Health Bylaws.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
None

/s/ Michael Hunn — *05/26/2023*
Authorized Signature — **Date**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

18. Approval of the CalOptima Health Fiscal Year 2023-24 Operating Budget and Non-Operating Items

Contact

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

Recommended Actions

1. Approve the CalOptima Health Fiscal Year 2023-24 Budget, as reflected in Attachment A: Fiscal Year 2023-24 Operating Budget for All Lines of Business and Non-Operating Items; and
2. Authorize the expenditures and appropriate the funds for the items listed in Attachment B: Administrative Budget Details and Attachment B1: Digital Transformation Administrative Budget Details, which shall be procured in accordance with CalOptima Health Policy GA.5002: Purchasing.

Background

The CalOptima Health Fiscal Year (FY) 2023-24 Budget provides revenues and appropriations for the period of July 1, 2023, through June 30, 2024, and includes the following budget categories:

- Lines of Business:
  - Medi-Cal
  - OneCare
  - Program for All-Inclusive Care for the Elderly (PACE)
  - Multipurpose Senior Services Program (MSSP)
  - Facilities (505 Building)

- Digital Transformation Strategy

- Non-Operating:
  - Net Investment Income
  - 500 Building

Staff is submitting a complete and balanced budget for all lines of business for approval, using assumptions based on the best available information to date. Pursuant to CalOptima Health policies GA.3202: CalOptima Health Signature Authority, GA.5002: Purchasing, and GA.5003: Budget Approval and Budget Reallocation, the Board of Directors (Board) approval of the budget authorizes the expenditure for the item and appropriates the funds requested without further Board action to the extent the Board has or is, as indicated in the budget attachments, delegating authority to management.

CalOptima Health's primary revenue source is the State of California. The May Revision to the state budget forecasts a $31.5 billion deficit. The Governor proposes to close the budget deficit through a combination of reduced and delayed spending, funding shifts, trigger cuts and revenue/borrowing. Staff will monitor legislative actions in the coming months and will return to the Board with recommendations in the event additional resources are needed beyond what was incorporated in this

budget. If enacted, state budget proposals that will have a direct or indirect impact on CalOptima Health's lines of business include:

- Implementation of a fourteen-month Public Health Emergency (PHE) unwinding period, with redetermination activities beginning on April 1, 2023;
- No sooner than January 1, 2024, expansion of Medi-Cal coverage to all income-eligible adults aged 26 through 49, regardless of immigration status;
- Continuation of CalAIM implementation;
- Continuation of Proposition 56 supplemental payments; and
- Renewal of the managed care organization tax effective April 1, 2023, through December 31, 2026.

Discussion

Management proposes an Operating Budget with an operating income of $17.6 million for FY 2023-24 as summarized in the following table and details below:

FY 2023-24 Operating Budget (in 000's except enrollment)

	Medi-Cal	OneCare	PACE	MSSP*	FY 2023-24 Budget
Average Monthly Enrollment	881,327	17,656	479	568	899,462
Revenue	$3,578,731	$383,712	$49,408	$3,042	$4,014,893
Medical Costs	$3,354,185	$379,225	$46,542	$2,612	$3,782,564
Administrative Expenses	$178,785	$31,932	$2,707	$1,300	$214,724
Operating Income/Loss	**$45,761**	**($27,445)**	**$159**	**($870)**	**$17,605**
Medical Loss Ratio (MLR)	93.73%	98.83%	94.2%	85.86%	94.21%
Administrative Loss Ratio (ALR)	5.00%	8.32%	5.48%	42.74%	5.35%

* MSSP enrollment included in Medi-Cal total.
Note: Values in above table may not add up due to rounding.

Operating Budget Analysis

Enrollment: The budget includes three significant changes in enrollment: (1) an increase in Medi-Cal enrollment effective January 1, 2024, from coverage expansion for adults aged 26 through 49, regardless of immigration status; (2) a decrease in Medi-Cal enrollment beginning July 2023 related to the resumption of normal Medi-Cal eligibility redetermination activities; and (3) a decrease in Medi-Cal enrollment from the implementation of a state-wide Medi-Cal direct contract with Kaiser Permanente beginning January 1, 2024. Staff anticipates seeing the impact of these activities on CalOptima Health's enrollment by June 2024.

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Revenue: The budget projects revenue for each line of business based on the most recent capitation rates available from the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS). Staff made additional adjustments based on member acuity and federal and state program and policy changes and included trend assumptions based on CalOptima Health's Rate Development Template submission to the State. The FY 2023-24 Operating Budget revenue on a per member per month (PMPM) basis is approximately 1.4% higher than the prior year's budget.

Medical Cost: The budget proposes a 94.21% MLR. Major components are in provider capitation, claims payments and case management & other medical costs. The budget includes the following:

- Implementation of Medi-Cal rebased capitation rates, including Whole Child Model adjustments and updated maternity kick rates to align with the State's reimbursement, effective July 2023;
- Incorporation of proposed risk arrangement changes for certain health networks; and
- Continuation of the implementation of CalAIM community support services offerings.

Several methods were utilized to develop the medical cost forecasts. Predominantly, projections were based on trends calculated from historical experience. Historical experience included several years' worth of data to incorporate trends for both the pre- and post-COVID-19 PHE declaration. Staff assigned various credibility to the different time periods depending on how representative they were of expected future utilization. In addition, adjustments were applied to account for known changes to operations, program structure, benefits, and regulatory policies. For newly implemented programs, staff used historical data, proxy data, and industry benchmarks, where available, and checked results for reasonability.

Administrative Expenses: The budget proposes a 5.35% ALR, which is higher than the prior year adjusted Board-approved ALR of 5.06%. The primary drivers for the higher administrative expenses in the proposed budget are:

- Personnel costs, including recent Board-approved actions to update the salary schedule, implementation of cost of living adjustments, continuation of certain employee supplemental benefits, and addition of a new work life balance stipend; and
- Non-salary expenses, including expenses to comply with mandated program requirements and technology updates to support business changes.

Staff prepared the General and Administrative budget using a "zero-based" budgeting methodology, which required departments to justify each expense before adding it to the budget. Attachment B: Administrative Budget Details provides additional information regarding all administrative expenses included in the FY 2023-24 Operating Budget.

Digital Transformation Strategy
In March 2022, the Board authorized a three-year Digital Transformation and Workplace Modernization Strategy and created a $100 million restricted reserve to fund digital transformation efforts. Attachment B1: Digital Transformation Administrative Budget Details provides additional information regarding operating expenses to implement initiatives in year two.

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Non-Operating
Net Investment Income: The budget projects $25.0 million in net investment income and is based on historical performance. This amount is higher than prior years due to projected market conditions and return on investments in FY 2023-24.

500 Building: Based on the projected revenue and estimated depreciation costs, the budget projects an estimated net deficit of approximately $393,000.

Status of Total Assets and Board-Designated Reserve Levels
As of March 31, 2023, CalOptima Health's total net assets are $1.5 billion. Of this amount, $577.5 is in Board-designated reserves, $67.1 million in capital assets, $441.1 million in unspent resources committed by the Board and $455.7 million is unallocated or unassigned resources.

Through previous actions, the Board has committed $566.2 million to strategic initiatives, quality/population health management, and grant programs. Many of these initiatives are multi-year commitments. As of March 31, 2023, $124.8 million has been spent, with $441.1 million left in unspent resources committed by the Board. Staff will track and report these initiatives separately through the monthly financial package and the quarterly net asset analysis.

Fiscal Impact
As outlined above and described in Attachment A, the budgeted FY 2023-24 Operating Income projects a surplus of $17,604,555.

A previous Board action on March 17, 2022, established a restricted Digital Transformation and Workplace Modernization Reserve in the amount of $100 million. An appropriation of $26,622,899 from the reserve will fund the operating expenses for the Digital Transformation Strategy in FY 2023-24.

The fiscal impact for non-operating net investment income and 500 Building net expense totals $24,607,447.

Rationale for Recommendation
Management submits the FY 2023-24 Operating Budget for all lines of business areas and non-operating items using the best information available to provide covered services to CalOptima Health's forecasted enrollment.

Concurrence
Troy Szabo, Outside General Counsel, Kennaday Leavitt
Finance and Audit Committee

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Attachments

1. Fiscal Year 2023-24 Operating Budget Presentation
2. Attachment A: Fiscal Year 2023-24 Operating Budget for All Lines of Business and Non-Operating Items
3. Attachment B: Administrative Budget Details
4. Attachment B1: Digital Transformation Administrative Budget Details

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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Fiscal Year 2023-24 Operating Budget

Board of Directors Meeting

June 1, 2023

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.

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- FY 2023-24 Budget Overview
  - Operating Budget
    - Enrollment
    - Medical Costs
    - Administrative Expenses
  - Digital Transformation Strategy
  - Non-Operating Items
- Recommended Actions
- Appendix
  - FY 2023-24 Operating Budget by Lines of Business
  - Net Asset Analysis, as of March 31, 2023

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Executive Summary

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CalOptima Health

Executive Summary

- Budget Objectives
  - Support CalOptima Health's mission and vision
  - Improve Access, Quality and Efficiency
  - Achieve a Balanced Operating Budget
  - Build Infrastructure and Capacity
- Federal and state policy decisions will impact CalOptima Health's budget
  - State budget deficit
  - Membership changes
    - Decreases from Medi-Cal redetermination and state-wide Kaiser Permanente direct contract
    - Increase from newly eligible adult expansion (ages 26-49)

FY 2023-24 Operating Budget:
REVENUE

$4,014,893,012

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CalOptima Health

FY 2023-24 Operating Budget:
EXPENSES

$3,997,288,457

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FY 2023-24 Operating Budget:
OPERATING MARGIN

$17,604,555

+0.44%

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Operating Budget Highlights

FY 2023-24 Operating Budget	
Average Enrollment	899,462
Revenue	$4,014,893,012
Medical Costs	$3,782,564,190
Medical Loss Ratio (MLR)	94.21%
Administrative Expenses	$214,724,267
Administrative Loss Ratio (ALR)	5.35%
Operating Income/Margin	$17,604,555 or 0.44%

CalOptima spends 94 cents of every dollar received on member care.

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FY 2023-24 Operating Budget Overview

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FY 2022-23 Budget vs. FY 2023-24 Budget

	FY 2022-23 Budget *	FY 2023-24 Budget	FY 2023-24 vs. FY 2022-23 Budget
Average Monthly Enrollment	909,523	899,462	(10,061)
Revenue	$4,002,166,211	$4,014,893,012	$12,726,801
Medical Costs	$3,763,117,812	$3,782,564,190	$19,446,378
Administrative Expenses	$202,394,737	$214,724,267	$12,329,530
Operating Income/Loss	**36,653,662**	**$17,604,555**	**($19,049,107)**
MLR	*94.03%*	*94.21%*	*0.19%*
ALR	*5.06%*	*5.35%*	*0.29%*

* Includes Board actions and budget adjustments as of March 2023

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Enrollment

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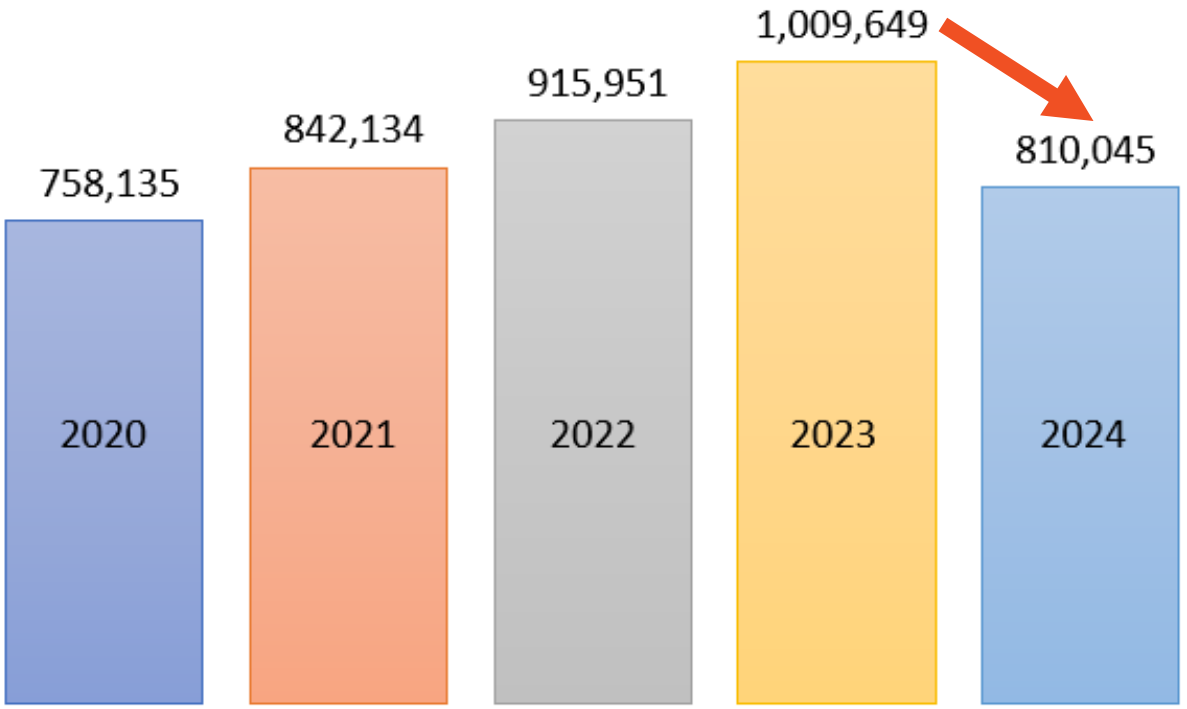
Consolidated June Enrollment: Actuals to Forecast



- Forecast shows nearly a 200,000 reduction in enrollment from June 2023 to June 2024 (-19.8%)

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CalOptima Health

Enrollment Projections: Average Member Months

LOB	FY 2020-21	FY 2021-22	FY 2022-23*	FY 2023-24 Budget	Change FY 2022-23 to FY 2023-24
Medi-Cal	792,005	859,319	944,042	**881,329**	(62,714)
OneCare Connect	14,747	14,671	7,159	**0**	(7,159)
OneCare	1,667	2,339	10,180	**17,661**	7,480
PACE	389	416	436	**479**	42
Total:	**808,807**	**876,744**	**961,817**	**899,468**	**(62,349)**

- Primary drivers include:
  - Effects of Medi-Cal eligibility redetermination activities
  - Addition of Adult Expansion members aged 26 - 49
  - Kaiser membership carved-out to state-wide Medi-Cal direct contract

* Forecast based on actuals through February 2023

Note: Rounding may impact calculations

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CalOptima Health

Medical and Administrative Costs:
Budget to Budget Comparison

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CalOptima Health

Medical Costs:
FY 2022-23 Budget vs. FY 2023-24 Budget

	FY 2022-23 Budget *	FY 2023-24 Budget	FY 2023-24 vs. FY 2022-23 Budget
Revenue	$4,002,166,211	$4,014,893,012	$12,726,801
Provider Capitation	**$1,404,781,904**	**$1,381,174,895**	**($23,607,009)**
Claims Payments	**$2,005,787,055**	**$2,091,377,791**	**$85,590,736**
Long Term Care (LTC)/Skilled Nursing Facilities	$622,961,488	$610,195,749	($12,765,739)
Prescription Drugs	$97,344,832	$124,146,899	$26,802,066
Professional, Facility and Other Ancillary	$1,285,480,735	$1,357,035,143	$71,554,408
Case Management & Other Medical	**$352,548,853**	**$310,011,503**	**($42,537,350)**
Total Medical Costs	**$3,763,117,812**	**$3,782,564,190**	**$19,446,378**
MLR	**94.03%**	**94.21%**	**0.18%**

* Includes Board actions and budget adjustments as of March 2023

Note: FY 2023-24 Budget Prescription Drugs includes Medicare lines of business only

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Administrative Expenses: FY 2022-23 Budget vs. FY 2023-24 Budget

	FY 2022-23 Budget *	FY 2023-24 Budget	FY 2023-24 Budget vs. FY 2022-23 Budget
Revenue	$4,002,166,211	$4,014,893,012	$12,726,801
Salaries, Wages & Benefits	**$131,364,544**	**$143,064,472**	**$11,699,928**
Non-Salary Expenses: Operating	**$62,371,705**	**$64,882,842**	**$2,511,137**
Professional Fees	$9,591,479	$10,484,480	$893,001
Purchased Services	$18,223,211	$16,921,012	($1,302,199)
Printing & Postage	$6,393,366	$6,248,500	($144,866)
Other Operating Expenses	$28,163,649	$31,228,850	$3,065,201
Non-Salary Expenses: Other	**$8,658,488**	**$6,776,953**	**($1,881,535)**
Depreciation & Amortization	$9,001,800	$7,342,800	($1,659,000)
Indirect Cost Allocation, Occupancy	($343,312)	(565,847)	($222,535)
Total Administrative Expenses	**$202,394,737**	**$214,724,267**	**$12,329,530**
ALR	**5.06%**	**5.35%**	**0.29%**

* Includes Board actions and budget adjustments as of March 2023

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Administrative Expenses:
Forecast to Budget Comparison

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Administrative Expenses: FY 2022-23 Forecast vs. FY 2023-24 Budget

	FY 2022-23 Forecast *	FY 2023-24 Budget	FY 2023-24 Budget vs. FY 2022-23 Forecast
Revenue	$4,145,341,137	$4,014,893,012	($130,448,126)
Salaries, Wages & Benefits	**$121,349,174**	**$143,064,472**	**$21,715,298**
Non-Salary Expenses: Operating	**$49,719,830**	**$64,882,842**	**$15,163,012**
Professional Fees	$7,559,303	$10,484,480	$2,925,177
Purchased Services	$13,912,589	$16,921,012	$3,008,423
Printing & Postage	$5,548,122	$6,248,500	$700,378
Other Operating Expenses	$22,699,816	$31,228,850	$8,529,034
Non-Salary Expenses: Other	**$4,938,685**	**$6,776,953**	**$1,838,268**
Depreciation & Amortization	$6,566,809	$7,342,800	$775,991
Indirect Cost Allocation, Occupancy	($1,628,124)	(565,847)	$1,062,277
Total Administrative Expenses	**$176,007,689**	**$214,724,267**	**$38,716,578**
ALR	**4.25%**	**5.35%**	**1.10%**

* Forecasted based on annualized actuals as of March 2023; Revenue excludes directed payments; Administrative Expenses exclude Board Commitments and Digital Transformation Strategy

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CalOptima Health

Administrative Budget: Bridge for FY 2022-23 Forecast vs. FY 2023-24 Budget

G&A Expense	Bridge	Description
Salaries, Wages & Benefits	**$21.7M**	Open positions ($10.6M), merit increase ($4.5M), cost of living ($2.2M), market and salary grade adjustments ($2.0M), work life balance stipends ($0.5M)
Non-Salary Expenses: Operating		
Professional Fees	**$2.9M**	Internal audit, consulting for new initiatives and software applications, compensation study, marketing and advertising support, financial and other required audits
Purchased Services	**$3.0M**	Broker agency commission for member enrollment, member interpretation and translation, and advertising and regulatory compliance services
Printing & Postage	**$0.7M**	Increase in mailing and processing of member packages and notices, postage costs, member enrollment, and increased support in marketing and outreach materials for members and providers
Other Operating Expenses	**$8.5M**	Increase in computer equipment replacement, software licenses and maintenance agreements, insurance policy increase, planned outreach activities for members, providers and community events, building maintenance and supplies, and staff education and development
Non-Salary Expenses: Other		
Depreciation & Amortization, Indirect Cost Allocation, Occupancy	**$1.8M**	FY 2022-23 and FY 2023-24 capital items placed in service
Total G&A	**$38.7M**	

Note: Assumes 7.5% vacancy factor in FY 2023-24 Budget based on actual experience

Totals may not add up due to rounding

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CalOptima Health

Digital Transformation Strategy

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CalOptima Health

Digital Transformation Strategy

	FY 2023-24 Budget
Salaries, Wages & Benefits	$7,315,793
Professional Fees	$2,105,000
Purchased Services	$1,860,000
Other Operating Expenses	$15,342,106
Total:	**$26,622,899**

- March 17, 2022: Board authorized a three-year strategy and created a $100 million restricted reserve to fund digital transformation efforts
- Proposed budget reflects operating expenses during Year Two of implementation

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Non-Operating

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500 Building

	FY 2023-24 Budget
Annual Revenue	$1,605,718
Estimated Operating Expenses	$1,998,271
Net Change:	**($392,553)**

- Building expenses are treated as non-operating for FY 2023-24

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CalOptima Consolidated Income Statement: Attachment A

Attachment A: Fiscal Year 2023-24 Operating Budget for All Lines of Business and Non-Operating Items

	Medi-Cal	OneCare	PACE	MSSP	Facilities	Other	Consolidated
Member Months	10,575,923	211,878	5,743	6,816	-	-	**10,793,544**
Avg Members	881,327	17,656	479	568	-	-	**899,462**
Revenues							
Capitation revenue	$ 3,578,731,345	$ 383,711,815	$ 49,407,644	$ 3,042,208	$ -	$ -	$ **4,014,893,012**
Total	$ 3,578,731,345	$ 383,711,815	$ 49,407,644	$ 3,042,208	$ -	$ -	$ **4,014,893,012**
Medical Costs							
Provider capitation	$ 1,210,953,834	$ 170,221,061	$ -	$ -	$ -	$ -	$ **1,381,174,895**
Professional Facility & Ancillary	$ 1,265,027,432	$ 70,337,505	$ 21,670,206	$ -	$ -	$ -	$ **1,357,035,143**
LTC/Skilled Nursing Facilities	$ 608,348,656	$ -	$ 1,451,606	$ 395,487	$ -	$ -	$ **610,195,749**
Prescription Drugs	$ -	$ 118,367,539	$ 5,779,360	$ -	$ -	$ -	$ **124,146,899**
Case Mgmt & Oth Medical	$ 269,855,469	$ 20,298,960	$ 17,640,534	$ 2,216,540	$ -	$ -	$ **310,011,503**
Total	$ 3,354,185,390	$ 379,225,066	$ 46,541,707	$ 2,612,027	$ -	$ -	$ **3,782,564,190**
MLR	*93.73%*	*98.83%*	*94.20%*	*85.86%*			*94.21%*
Gross Margin	$ 224,545,955	$ 4,486,750	$ 2,865,937	$ 430,181	$ -	$ -	$ **232,328,822**
Administrative Expenses							
Salaries, Wages, & Employee Benefits	$ 125,743,461	$ 14,014,634	$ 2,201,599	$ 1,104,778	$ -	$ -	$ **143,064,472**
Non-Salary Operating Expenses	$ 54,554,814	$ 6,534,141	$ 316,182	$ 105,300	$ 3,372,405	$ -	$ **64,882,842**
Depreciation & Amortization	$ 4,800,000	$ -	$ 10,800	$ -	$ 2,532,000	$ -	$ **7,342,800**
Indirect Cost Allocation, Occupancy Expense	$ (6,313,095)	$ 11,383,000	$ 178,353	$ 90,300	$ (5,904,405)	$ -	$ **(565,847)**
Total	$ 178,785,179	$ 31,931,776	$ 2,706,934	$ 1,300,378	$ -	$ -	$ **214,724,267**
ALR	*5.00%*	*8.32%*	*5.48%*	*42.74%*			*5.35%*
Operating Income/(Loss)	**$ 45,760,775**	**$ (27,445,026)**	**$ 159,003**	**$ (870,197)**	**$ -**	**$ -**	**$ 17,604,555**
Digital Transformation Strategy						$ (26,622,899)	$ **(26,622,899)**
Non-Operating							
Net Investment Income						$ 25,000,000	$ **25,000,000**
500 Building						$ (392,553)	$ **(392,553)**
Total Non-Operating						**$ 24,607,447**	$ **24,607,447**

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CalOptima Health

Recommended Actions

- Approve CalOptima Health Fiscal Year 2023-24 Budget, as reflected in Attachment A: Fiscal Year 2023-24 Operating Budget for All Lines of Business and Non-Operating Items

- Authorize the expenditures and appropriate the funds for items listed in Attachment B: Administrative Budget Details and Attachment B1: Digital Transformation Administrative Budget Details
  - Items shall be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy

Appendix: FY 2023-24 Operating Budget by Line of Business

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Medi-Cal

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Medi-Cal Budget

	FY 2021-22 Actual	FY 2022-23 Forecast*	FY 2023-24 Budget
Average Monthly Enrollment	859,290	931,193	881,327
Revenue	$3,798,327,448	$3,733,514,239	$3,578,731,345
Medical Costs	$3,559,811,085	$3,464,808,262	$3,354,185,390
Administrative Expenses	$125,917,940	$148,790,339	$178,785,179
Operating Income/Loss	**$112,598,423**	**$119,915,638**	**$45,760,775**
MLR	93.72%	92.80%	93.73%
ALR	3.32%	3.99%	5.00%

* Forecasted as of March 2023

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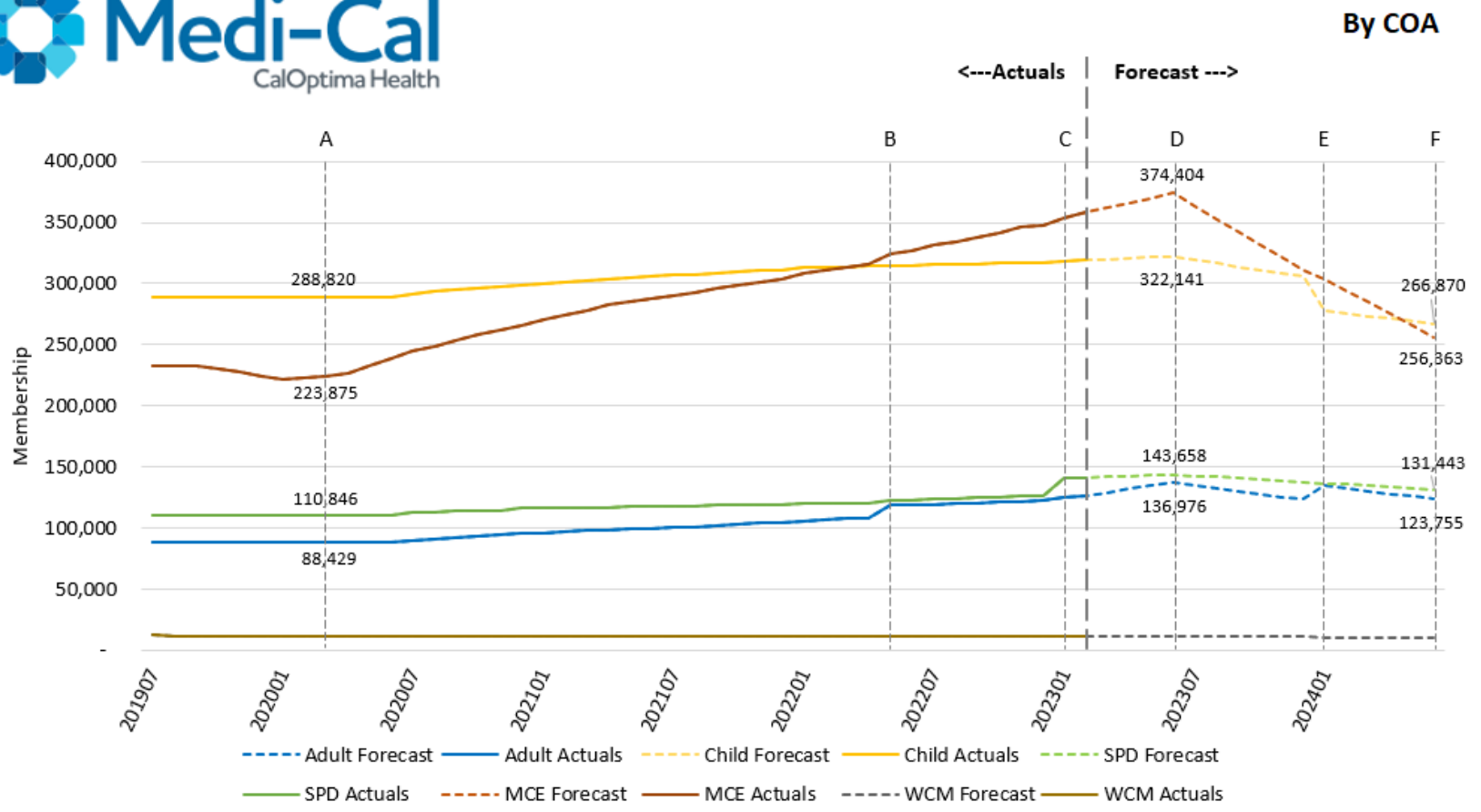
Medi-Cal Enrollment: Trend and Forecast

Medi-Cal
CalOptima Health



A. March 2020 - Beginning of PHE
B. May 2022 - Undoc. Adults Age 50+ (17K)
C. January 2023 - OCC enrollment moves to OC and MC (Duals)
D. July 2023 - Redetermination Begins
E. January 2024 - Undoc. Adults Age 26-49 (+45K) and Kaiser Transition (-55K)
F. June 2024 - Forecasted Redetermination Catch-up Complete

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Medi-Cal Revenue

- Rate assumptions

	Medi-Cal Classic	Medi-Cal Expansion	Medi-Cal Whole Child Model (WCM)
Base Rates	July – December 2023: Calendar Year (CY) 2023 rates		
	January – June 2024: Draft CY 2024 rates expected October 2023		
	• Assumes 3% increase	• Assumes 1% increase	• Assumes 0% increase
Dual base rates (formerly Coordinated Care Initiative (CCI) rates)	• Effective January 2023, CCI cohort rates discontinued and replaced with Dual base rates • Assumes revenue neutrality		NA

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Medi-Cal Rebasing Results

- An actuarially sound process to recalibrate base capitation rates paid to health networks
- Results:

Variance %

COA	Facility	Professional	Combined
Child	21.7%	14.7%	**16.5%**
Adult	20.4%	21.3%	**20.9%**
SPD	21.3%	7.0%	**15.1%**
WCM	9.5%	0.5%	**6.2%**
Expansion	-5.4%	-11.6%	**-8.5%**
Total	**5.5%**	**0.5%**	**2.9%**

- Effects on Rates
  - Reduction to Medi-Cal Expansion; Increase to Medi-Cal Classic
  - Maternity kick supplemental payment broadened to include all live births (non-SPD)
  - Whole Child Model based on experience; risk corridor replaced with reinsurance inclusion

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OneCare

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OneCare Budget

	FY 2022-23 Forecast *	FY 2023-24 Budget
Average Monthly Enrollment	17,350	17,656
Revenue	$365,920,260	$383,711,815
Medical Costs	$355,371,135	$379,225,066
Administrative Expenses	$23,687,845	$31,931,776
Operating Income/Loss	**($13,138,720)**	**($27,445,026)**
MLR	97.12%	98.83%
ALR	6.47%	8.32%

* OneCare Connect enrollment transitioned to OneCare D-SNP on January 1, 2023. FY 2022-23 Forecast uses January – March OneCare experience.

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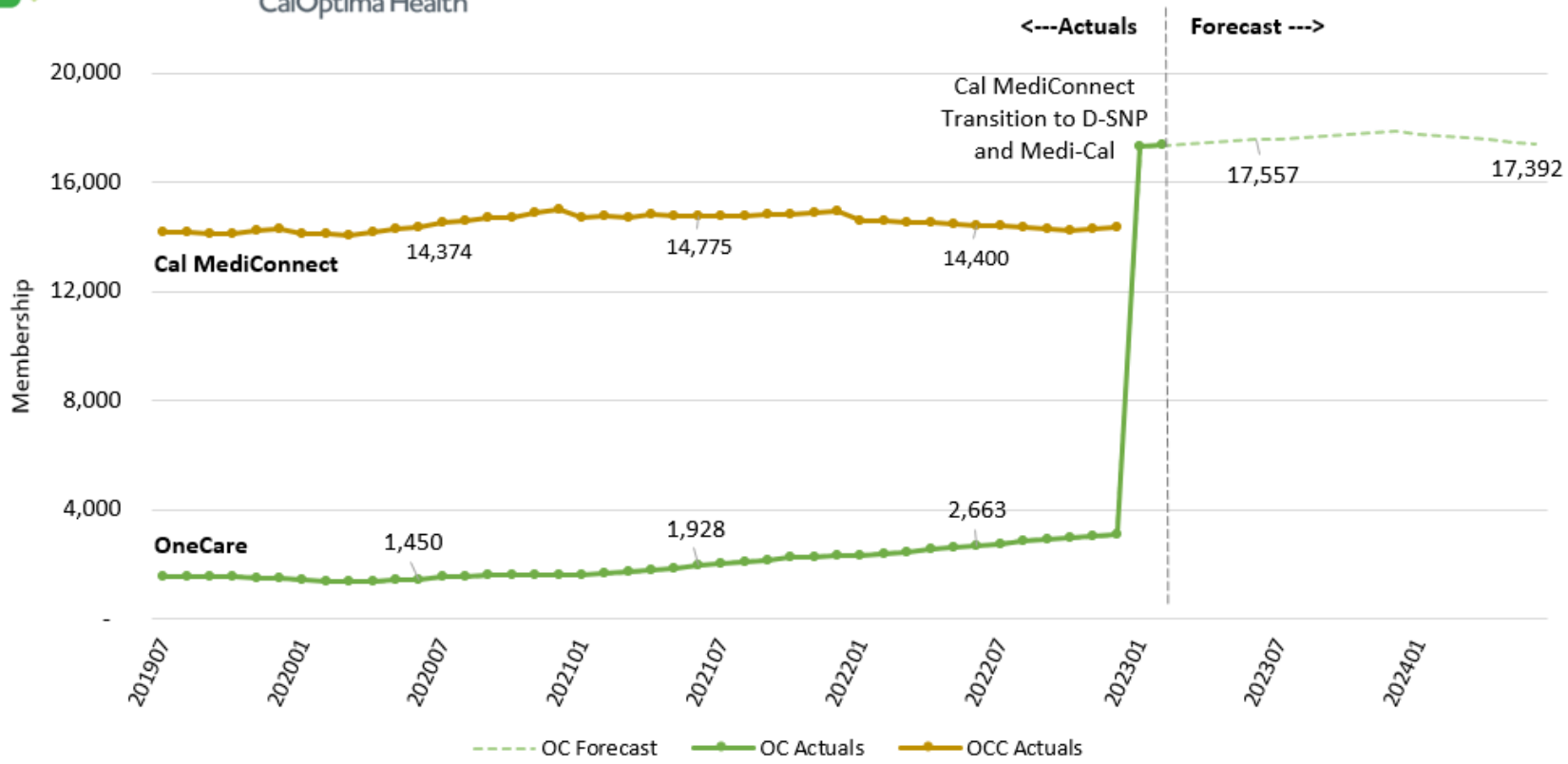
CalOptima Health

OneCare Enrollment: Trend and Forecast



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OneCare Budget Assumptions

- Enrollment projected to increase 1.8% when comparing to the prior year consolidated OneCare and OneCare Connect enrollment

- OneCare revenue rate assumptions*
  - CalOptima Health will continue to absorb 2% sequestration reduction

Medicare Part C	Medicare Part D
• CMS CY 2023 Monthly Membership Report actuals • Forecasted 3.3% increase to Part C revenue PMPM. Combination of base rate and RAF score.	• CMS CY 2023 Monthly Membership Report actuals • Forecasted 7.8% increase to Part D revenue PMPM. Combination of base rate, RAF score and other adjustments.

- Medical Costs
  - Uses current capitation percent of premium (POP) percentages
  - Forecasts increases primarily in pharmacy, inpatient and other outpatient services
  - Includes expenses for approved supplemental benefits

* Used most current rates available

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CalOptima Health

OneCare Program Improvement Opportunities

- Review current operational practices to improve efficiency, accuracy and quality (Star Ratings)
- Improve data submission processes to accurately reflect diagnoses for Risk Adjustment Factors
  - Edifecs – Encounter submission vendor implementation
  - Medicare Annual Wellness Visits to capture appropriate member diagnostic information
- Promote enrollment growth through utilization of brokers
- Utilize Value-Based Insurance Design (VBID) to support the current level of supplemental benefits (pending CMS final approval)

PACE

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PACE Budget

	FY 2021-22 Actual	FY 2022-23 Forecast *	FY 2023-24 Budget
Average Monthly Enrollment	417	434	479
Revenue	$41,991,987	$43,503,806	$49,407,644
Medical Costs	$34,575,969	$39,391,000	$46,541,707
Administrative Expenses	$2,228,121	$2,467,659	$2,706,934
Operating Income/Loss	**$5,187,897**	**$1,645,147**	**$159,003**
MLR	82.34%	90.55%	94.20%
ALR	5.31%	5.67%	5.48%

* Forecasted as of March 2022

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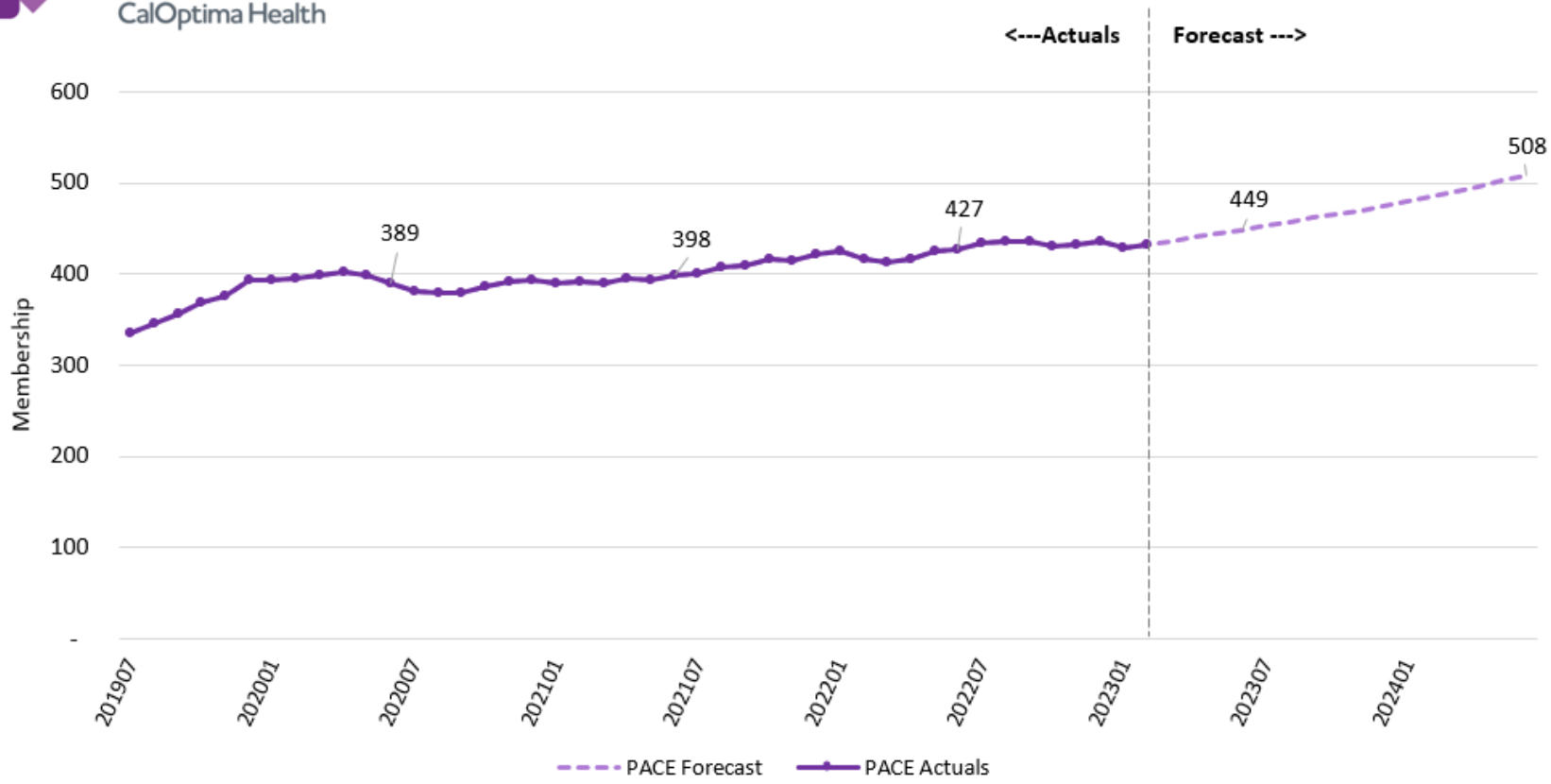
CalOptima Health

PACE Enrollment: Trend and Forecast



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PACE Budget Assumptions

- PACE revenue rate assumptions

Medicare Part C	Medicare Part D	Medi-Cal
• CMS CY 2023 Monthly Membership Report actuals • Forecasted 6.3% increase to Part C revenue PMPM beginning CY 2024. Combination of base rate and RAF score changes.	• CMS CY 2023 Monthly Membership Report actuals • Forecasted 0.1% increase to Part D revenue PMPM beginning CY 2024. Combination of base rate, RAF score and other adjustments.	PMPM rates based on CY 2023 rates and reflect no trend into CY 2024 • Utilized Rate Development Template (RDT) reported cost • RDT credibility increasing annually with additional membership growth

- Medical costs
  - Based on mix of actual experience and industry benchmarks
  - Reclassifies 91% of some administrative expenses as medical costs to better reflect the actual costs of delivering medical care
  - Assumes transition back to pre-pandemic operations at the PACE Center

Note: Used most current rates available

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Net Asset Analysis, as of March 31, 2023

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CalOptima Health

Reserve Summary (as of March 2023)

	Amount (in millions)
Board Designated Reserves*	$577.5
Capital Assets (Net of Depreciation)	$67.1
Resources Committed by the Board	$441.4
Resources Unallocated/Unassigned*	$455.7
Total Net Assets	$1,541.8

* Total of Board-designated reserves and unallocated resources can support approximately 103 days of CalOptima Health's current operations

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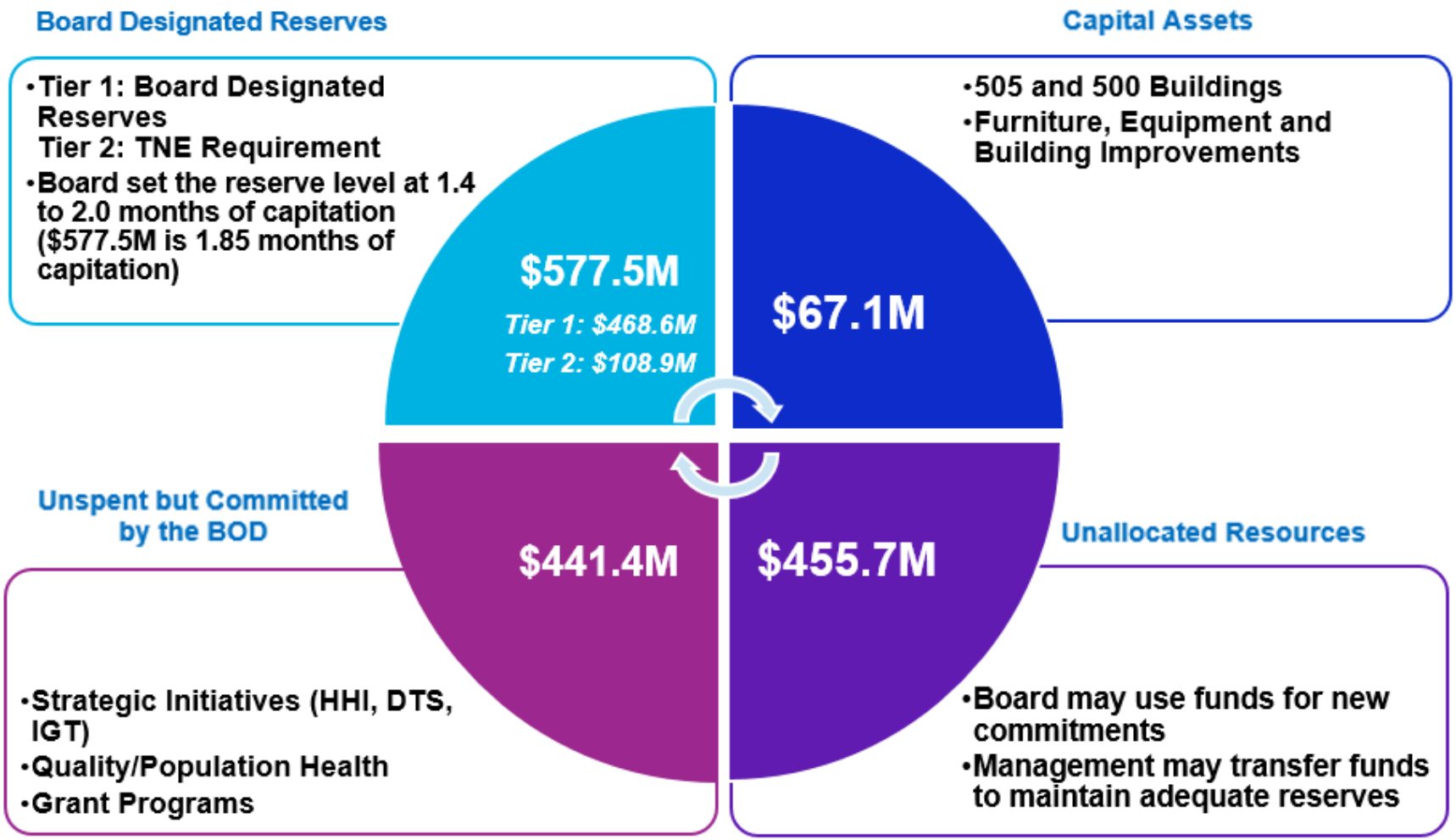
Net Asset Analysis (as of March 2023)



Note: Please find more program details in CalOptima Health's monthly financials.

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Board Committed Resources (as of March 2023)

Unspent Resources Committed by the Board: $441.4M

Board-approved Initiatives	Status	Board Approved Amount	Spent Amount	Unspent Balance	Duration
Strategic Initiatives					
Homeless Health Initiative	In progress	$59.9	$38.4	$21.5	Multiple
Housing and Homelessness Incentive	In progress	40.1	0.0	40.1	Multiple
Digital Transformation Strategy (DTS)	In progress	100.0	7.3	92.7	FY 23 - FY 25
Intergovernmental Transfers (IGT)	In progress	111.7	52.1	59.6	Multiple
Subtotal		***$311.7***	***$97.8***	***$213.9***	
Quality/Population Health Management					
OneCare Member Health Incentives	Close to starting	1.0	0.0	1.0	CY 2023
Five-Year Hospital Quality Program	In progress	153.5	0.0	153.5	CY 2023 - CY 2027
Medi-Cal Annual Wellness Initiative	Close to starting	15.0	0.0	15.0	CY 2023
Skilled Nursing Facility Access Program	Close to starting	10.0	0.0	10.0	FY 24 - FY 26
In-Home Care Pilot Program with the UCI	In progress	2.0	0.0	2.0	CY 2023 - CY 2024
NAMI Orange County Peer Support Program	In progress	5.0	0.0	5.0	CY 2023 - CY 2027
Subtotal		***$186.5***	***$0.0***	***$186.5***	
Grant Programs					
CalFresh Outreach Strategy	In progress	2.0	1.0	1.0	FY 22 - FY 23
Mind OC Grant (Orange)	Finished	1.0	1.0	0.0	One-time
Mind OC Grant (Irvine)	Finished	15.0	15.0	0.0	One-time
Coalition of OC Community Health Centers	In progress	50.0	10.0	40.0	FY 23 - FY 27
Subtotal		***$68.0***	***$27.0***	***$41.0***	
Total		**$566.2**	**$124.8**	**$441.4**	

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Attachment A: Fiscal Year 2023-24 Operating Budget for All Lines of Business and Non-Operating Items

	Medi-Cal	OneCare	PACE	MSSP	Facilities	Other	Consolidated
Member Months	10,575,923	211,878	5,743	6,816	-	-	**10,793,544**
Avg Members	881,327	17,656	479	568	-	-	**899,462**
Revenues							
Capitation revenue	$ 3,578,731,345	$ 383,711,815	$ 49,407,644	$ 3,042,208	$ -	$ -	**$ 4,014,893,012**
Total	$ 3,578,731,345	$ 383,711,815	$ 49,407,644	$ 3,042,208	$ -	$ -	**$ 4,014,893,012**
Medical Costs							
Provider capitation	$ 1,210,953,834	$ 170,221,061	$ -	$ -	$ -	$ -	**$ 1,381,174,895**
Professional Facility & Ancillary	$ 1,265,027,432	$ 70,337,505	$ 21,670,206	$ -	$ -	$ -	**$ 1,357,035,143**
LTC/Skilled Nursing Facilities	$ 608,348,656	$ -	$ 1,451,606	$ 395,487	$ -	$ -	**$ 610,195,749**
Prescription Drugs	$ -	$ 118,367,539	$ 5,779,360	$ -	$ -	$ -	**$ 124,146,899**
Case Mgmt & Oth Medical	$ 269,855,469	$ 20,298,960	$ 17,640,534	$ 2,216,540	$ -	$ -	**$ 310,011,503**
Total	$ 3,354,185,390	$ 379,225,066	$ 46,541,707	$ 2,612,027	$ -	$ -	**$ 3,782,564,190**
MLR	***93.73%***	***98.83%***	***94.20%***	***85.86%***			***94.21%***
Gross Margin	$ 224,545,955	$ 4,486,750	$ 2,865,937	$ 430,181	$ -	$ -	**$ 232,328,822**
Administrative Expenses							
Salaries, Wages, & Employee Benefits	$ 125,743,461	$ 14,014,634	$ 2,201,599	$ 1,104,778	$ -	$ -	**$ 143,064,472**
Non-Salary Operating Expenses	$ 54,554,814	$ 6,534,141	$ 316,182	$ 105,300	$ 3,372,405	$ -	**$ 64,882,842**
Depreciation & Amortization	$ 4,800,000	$ -	$ 10,800	$ -	$ 2,532,000	$ -	**$ 7,342,800**
Indirect Cost Allocation, Occupancy Expense	$ (6,313,095)	$ 11,383,000	$ 178,353	$ 90,300	$ (5,904,405)	$ -	**$ (565,847)**
Total	$ 178,785,179	$ 31,931,776	$ 2,706,934	$ 1,300,378	$ -	$ -	**$ 214,724,267**
ALR	***5.00%***	***8.32%***	***5.48%***	***42.74%***			***5.35%***
Operating Income/(Loss)	**$ 45,760,775**	**$ (27,445,026)**	**$ 159,003**	**$ (870,197)**	**$ -**	**$ -**	**$ 17,604,555**
Digital Transformation Strategy						$ (26,622,899)	**$ (26,622,899)**
Non-Operating							
Net Investment Income						$ 25,000,000	**$ 25,000,000**
500 Building						$ (392,553)	**$ (392,553)**
Total Non-Operating						**$ 24,607,447**	**$ 24,607,447**

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Attachment B: Administrative Budget Details

	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2023-24 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Insurance Premiums - Errors and Omissions Professional Liability - General and Property Liabilities - Excess Liabilities - Commercial Auto - Directors and Officers (D&O) - Network/Privacy (Cyber), Crime, Employment Practices Liability (EPL) - Earthquake, Pollution and Umbrella - Wage and Hour Coverage	2,788,310	X	X
Other Operating Expenses	Facets Core System (Enrollment, Claims, Authorizations and Other Modules) License Renewal and Maintenance. Facets True Up Membership	2,311,815	X	X
Other Operating Expenses	Replacement Hardware for Operating System Upgrade, Desktop Software Licenses, Laptop and Desktop Replacements, Computer Equipment Refresh and Other Minor Computer Equipment	2,010,000	X	X
Other Operating Expenses	Corporate Software Maintenance (Provider Sanctioning and Analytics, Data Warehouse Cleansing, Analytics, Business Application Workflow, Website Content Management, Compliance and Other Corporate Applications)	1,910,418	X	X
Other Operating Expenses	Telecommunications and Network Connectivity Expenses, Business Telephones and Accessories (Desk Phones, Headsets, Tablets and Accessories)	1,800,000	X	X
Other Operating Expenses	Enterprise Subscriptions, Licenses and Certifications, Support for Service Management on Foundational Modules, Project and Portfolio Management, and Asset Management	1,645,378	X	X
Other Operating Expenses	Operating Systems and Office Software Suite License Costs to Support Entire Organization	1,500,000	X	X
Other Operating Expenses	Network Connectivity Maintenance and Support for CalOptima Health Sites (Network Monitoring Tools, Web Filters, All Main Distribution Frame and Intermediate Distribution Frame Batteries, Internet Optimizers, Routers, Wireless Application Protocol Devices, Other Tools)	916,031	X	X
Other Operating Expenses	User Licenses for Medicare Claims Pricing Software	897,209	X	X
Other Operating Expenses	Maintenance and Support Annual Renewal for the Telecommunications Network Systems	841,588	X	X
Other Operating Expenses	Application Software Maintenance - IT Development Tools (Data Modeling, Architecture, Technical Libraries, Documentation, Technical Frameworks, Electronic Data Interchange, Software Development Testing)	812,312	X	X
Other Operating Expenses	Training & Seminar - Professional Development and Education - System and Software Update Training - Process Improvement Training - Financial and Reporting Software Upgrade and Training - Training Classes for Facility Management, Environmental and Safety Issues - Training Classes for Professional Certifications and Continuing Legal Education	811,204	X	X
Other Operating Expenses	Real Time Claims Adjudication Function One Time License Fee and Annual Maintenance	743,144	X	X
Other Operating Expenses	Provider and Physician Credentialing System Maintenance and License Renewal	719,540	X	X
Other Operating Expenses	Server Connectivity Maintenance and Support for Server Equipment (Servers, Storage, Virtual Machine Licenses, Backup Software)	688,000	X	X
Other Operating Expenses	Association Membership Dues (Provide Advocacy, Program Support, Technical Support Regarding State and Federal Regulatory Issues)	658,500	X	X
Other Operating Expenses	Human Resources Corporate Application Software Maintenance (Training, Recruitment, Performance Evaluation, HR Benefits, Employee Time and Attendance and Payroll)	644,000	X	X

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	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	Objective of the Item Proposed	Budget FY 2023-24 Input	Authorization	Appropriation
Other Operating Expenses	Maintenance of Desktop Application Software and Hardware	482,400	X	X
Other Operating Expenses	Purchases and Installation of Office Furniture for Adds, Moves, Furniture, Fixture and Equipment, and Various Other Articles of Minor Equipment	400,000	X	X
Other Operating Expenses	Software Licenses and Subscriptions Pertaining to Capital Projects	369,000	X	X
Other Operating Expenses	Information Security Data Loss Prevention Solution Annual Maintenance	350,000	X	X
Other Operating Expenses	Contract Management System	305,815	X	X
Other Operating Expenses	24/7 Support to Assist CalOptima Health's Operating Systems and Office Software Suite Related Questions and Issues	300,000	X	X
Other Operating Expenses	Email Security Anti-Phishing, Intrusion Prevention, Vulnerability Management, Security Incident and Event Management Software and Password Vault	300,000	X	X
Other Operating Expenses	Maintenance for Windows and Carpet Cleaning, Furniture Repair, Doors, Audio Visual Equipment, Plumbing and Other General Maintenance Needs	265,000	X	X
Other Operating Expenses	Office Supplies (Paper, Toner, Batteries, Mouse Pads, Keyboards, Environmental Health and Safety, Disaster Recovery, Other Miscellaneous Items) for Company-Wide Usage	225,000	X	X
Other Operating Expenses	Employee Engagement Events and CalOptima Health Logo Apparel	224,900	X	X
Other Operating Expenses	Sponsorship, Registration Fees and Other Related Costs for New and Anticipated Community Events, Health Fairs, Venue Rental, Services and Supplies	206,000	X	X
Other Operating Expenses	Finance Corporate Applications Software Maintenance (Accounting, Finance and Vendor Management Systems)	205,435	X	X
Other Operating Expenses	Tuition Reimbursement for Staff Development and Organizational Development Programs (CalOptima Health Special Speakers, Trainers, Computer Classes, Other Training Events)	186,500	X	X
Other Operating Expenses	Travel - Conferences/Seminars and Meetings for Managers and Staff - State Meetings Related to Regulatory and Legislative Issues, Strategic Development - Association Meetings - Vendor Site Visits, Field Staff Visits - Mileage and Parking Reimbursement for Community Events and Presentations, Provider Offices and Member Enrollment	165,859	X	X
Other Operating Expenses	Software to Generate and Interface with Facets Letters	158,800	X	X
Other Operating Expenses	Professional Dues and Member Fees for Various Professional Associations	122,587	X	X
Other Operating Expenses	Additional Software License and Upgrade Costs for Operating Systems and Office Software Suite	100,000	X	X
Other Operating Expenses	Database Administrator License Renewals, Maintenance and Support	88,500	X	X
Other Operating Expenses	Medical Licenses and Required Certifications	81,132	X	X
Other Operating Expenses	Office Supplies for Various Departments' Needs for Everyday Operations	78,734	X	X
Other Operating Expenses	Subscription Renewal for Standard Medical Coding Schedules and Multiple User Licenses	75,000	X	X
Other Operating Expenses	Strategic Development, Orange County Indicators Report and Other Professional Membership Dues	68,834	X	X
Other Operating Expenses	Maintenance and Support for the Production/Development of Citrix Operating System/Software Environments	54,000	X	X
Other Operating Expenses	Subscriptions for Existing Software and Databases	53,525	X	X
Other Operating Expenses	Human Resources Program Books, Surveys, Mentoring and Succession Planning, Video Maker and Various Licenses	40,570	X	X
Other Operating Expenses	Employee Appreciation Events	40,000	X	X
Other Operating Expenses	Board Member Stipends, Memberships, Conferences, Training and Travel	32,600	X	X

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Attachment B: Administrative Budget Details

	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	Objective of the Item Proposed	Budget FY 2023-24 Input	Authorization	Appropriation
Other Operating Expenses	Chief Medical Officer Physician Advisory Committee Outreach	31,200	X	X
Other Operating Expenses	Food Services for Community Events and Supporting New Initiatives	30,000	X	X
Other Operating Expenses	Subscription Fees for Various Licenses, Literature and Organizations	27,154	X	X
Other Operating Expenses	Supplies and Costs Associated with Various Outreach, Community Events, Sponsorships and Health Fairs	26,180	X	X
Other Operating Expenses	Promotional and Outreach Activities to Help Support CalOptima Health Programs and Initiatives	25,000	X	X
Other Operating Expenses	Provider Outreach, Lunch and Learn	25,000	X	X
Other Operating Expenses	Food Services Allowances, as Needed, for Sponsoring Member and Provider Meetings, Conferences, Department Meetings and Other Events	23,125	X	X
Other Operating Expenses	Enterprise Architecture Software Tools and Libraries	20,000	X	X
Other Operating Expenses	Subscription Fees for Electronic Surveys, Education Videos for Members and Associations	19,080	X	X
Other Operating Expenses	Food Services for CalOptima Health Informational Series, Legislative Luncheon Events, Member and Provider Meetings/Conferences, Board Meetings and Other Events	17,750	X	X
Other Operating Expenses	General Supplies for CalOptima Health Staff	15,000	X	X
Other Operating Expenses	Subscription Fees for Both Clinical and Programmatic Support, and Normal Maintenance of Certification Licensure	14,600	X	X
Other Operating Expenses	Coding Licenses and Books	14,200	X	X
Other Operating Expenses	Maintenance and Support for Printers	6,000	X	X
Other Operating Expenses	Food Services for Annual CalOptima Health Event to Promote Mental Health Awareness and Other Events	6,000	X	X
Other Operating Expenses	Food Services for Advisory Committees, Existing and New Collaboratives, Stakeholder Engagement For New Initiatives	4,800	X	X
Other Operating Expenses	Food Services for Provider Advisory Committee, CalOptima Health Community Network Lunch and Learn Events and Anniversary Event	4,000	X	X
Printing & Postage	Print and Fulfillment for Regular Mailings of Daily/Monthly Packets	1,121,000	X	X
Printing & Postage	Postage for Maintenance of Business, Direct Mailer, QMB Mailings, Ad Hoc and New Projects	1,760,000	X	X
Printing & Postage	General Postage for Outgoing Mail	741,000	X	X
Printing & Postage	Print and Fulfillment for Newsletters	422,000	X	X
Printing & Postage	Printing of the Annual Report to the Community, Holiday Cards, Provider Press Newsletter, Stock Photo Fees, Advocacy Items, Strategic Plan Booklet, Direct Mail, Marketing Material and Ad Hoc Collateral Materials	295,000	X	X
Printing & Postage	QMB Mailings, Ad Hoc and New Projects	197,000	X	X
Printing & Postage	Mail Services Charges, Courier/Delivery of Print Materials	68,100	X	X
Printing & Postage	Miscellaneous Member Materials, Printing Expenses and Supplies for Various Departments	47,600	X	X
Printing & Postage	Printing Services for Facilities Projects and Events, Safety and Security, Other CalOptima Health Departments' Printing Needs	24,000	X	X
Printing & Postage	Provider Relations Provider Directory Validation Forms, Annual In-Service Letters and Attestation Forms, Access and Availability Required Mailings and Postage Required to Ensure Provider Training and Education Compliance	10,000	X	X
Printing & Postage	Flyers, Brochures and Business Cards	5,000	X	X
Professional Fees	General and Adversarial Legal Fees for Outside Legal Counsel	3,200,000	X	X
Professional Fees	Government Affairs Contract and Management of State, Federal and Local Lobbyists	594,000	X	X
Professional Fees	Employee Engagement and Feedback, Executive Recruiter Expenses, Direct Hire Fees, Leave and Accommodation and Ad Hoc Consulting	500,000	X	X
Professional Fees	Compensation and Job Classification Study	500,000	X	X

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	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	Objective of the Item Proposed	Budget FY 2023-24 Input	Authorization	Appropriation
Professional Fees	Consulting Fees To Support Campaign Development and Advertising Strategy	442,000	X	X
Professional Fees	Health Insurance Portability and Accountability Act (HIPAA) Security Compliance, including Risk Management, Assessment and Network Penetration, Health Check on Existing Cyber Security Tools	438,000	X	X
Professional Fees	Internal Audit on Operations	400,000	X	X
Professional Fees	Consulting Fees To Support Program Outreach and Social Media Efforts, Acquiring Data for Strategic Direction	380,000	X	X
Professional Fees	Consultant for Medi-Cal Mock Audit and Other Required Audits	360,000	X	X
Professional Fees	Consulting Fees for Organizational and Strategic Plan Support	300,000	X	X
Professional Fees	Professional Services for Software Development Tools Enhancements and Frameworks in the Area of Data Warehouse, EDI and System Integration, Business Intelligence	300,000	X	X
Professional Fees	Annual IBNR Certification, Network Support and Other Related Actuarial Consulting Services	269,500	X	X
Professional Fees	Consulting Fees for Government Affairs Support	260,000	X	X
Professional Fees	Medical Loss Ratio Audit	250,635	X	X
Professional Fees	Core Systems Upgrade Consultation, Technical Training and Other Core Application Support	249,000	X	X
Professional Fees	Annual Financial Audit	216,000	X	X
Professional Fees	Support for Implementation of Strategic Plan, Initiatives Aligned with Strategic Plan, Equity Initiative Activities, Duals Population Market Analysis and Network Model Change Evaluation	200,000	X	X
Professional Fees	Space Planning Services, Mechanical Engineering Consultant, and Broker Services	186,000	X	X
Professional Fees	Cloud Platform Assistance, Security Services and Miscellaneous Consulting/Professional Services	150,000	X	X
Professional Fees	Investment Advisory Support Services	90,000	X	X
Professional Fees	External Peer Review, Medical Records Retrieval, and Compliance and Ethics Hotline	77,000	X	X
Professional Fees	Professional Fees for Other Post Employment Benefits (OPEB) and Various Accounting and Related Consulting Services	72,500	X	X
Professional Fees	Consulting Services for Budget and Vendor Management Support	30,000	X	X
Professional Fees	Evaluation of End to End Workflow for System/Process Improvements	30,000	X	X
Professional Fees	Professional Consultant Services for Enterprise Project Management Office	10,000	X	X
Professional Fees	Samaritan Program Pilot	5,000	X	X
Purchased Services	Claims Prepayment Editing Services	2,664,000	X	X
Purchased Services	Face to Face Interpreter Services, Telephonic and Video Interpreter Services, Translation Services for Threshold Languages, Translation Audit Review and Translation Skill Assessment and Testing	2,165,544	X	X
Purchased Services	Overpayment Identification Services	1,653,000	X	X
Purchased Services	Electronic Data Interchange Institutional Claims	1,287,000	X	X
Purchased Services	Coordination of Benefits (COB) Project	1,011,000	X	X
Purchased Services	Third Party Check Printing and Mailing Fees	420,000	X	X
Purchased Services	Business Bank Fees	414,000	X	X
Purchased Services	Claims Imaging and Indexing Services	414,000	X	X
Purchased Services	Supplemental Security Income (SSI) Conversion Services	371,000	X	X
Purchased Services	Long Term Care Rate Adjustments	366,000	X	X
Purchased Services	Radio, Television, Print, Outdoor, Digital Advertising Campaign to Encourage Use of CalOptima Health Covered Preventative Services	300,000	X	X
Purchased Services	Radio, Television, Print, Outdoor, Digital Advertising and Other Media to Promote and Support Awareness Campaigns and Satellite Office Campaign	276,000	X	X
Purchased Services	Telecom Expense Management System, Other Ongoing Services	180,000	X	X

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Attachment B: Administrative Budget Details

	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	Objective of the Item Proposed	Budget FY 2023-24 Input	Authorization	Appropriation
Purchased Services	Insurance Broker Services	175,000	X	X
Purchased Services	Medicare Third Party Liability (TPL)	165,000	X	X
Purchased Services	Recruitment Advertisement and Sourcing	155,000	X	X
Purchased Services	Offsite Backup Tape Storage and Services, Slotted Media Storage	153,600	X	X
Purchased Services	Background Screening	137,000	X	X
Purchased Services	Fraud, Waste and Abuse (FWA) Recovery Fees	130,000	X	X
Purchased Services	Benefit Broker Services	115,000	X	X
Purchased Services	Sponsorship of Television Network Featuring Brand Placement and Raising Awareness of Health Topics	70,000	X	X
Purchased Services	Telework, Handling, Deliveries and Arm Guards	69,996	X	X
Purchased Services	Flexible Spending Accounts (FSA)/Consolidated Omnibus Budget Reconciliation Act (COBRA)	65,000	X	X
Purchased Services	Regulatory 508 Compliance Remediation Services for PDF Files to Make Member, Provider, Board and Other Materials Accessible to People With Disabilities on the Website as Required by CMS, DHCS and Section 508 Regulations	63,000	X	X
Purchased Services	Healthcare Productivity Automation Services	60,000	X	X
Purchased Services	Executive Coaching	50,000	X	X
Purchased Services	Retirement Funds Advisory	50,000	X	X
Purchased Services	TB Shots and Other General Purchased Services for Facilities Support	46,000	X	X
Purchased Services	Member Experience Survey and Workforce Enhancement	42,000	X	X
Purchased Services	Employee Assistance Program	40,000	X	X
Purchased Services	Data Scanning and Storage	36,000	X	X
Purchased Services	Employee Wellness and Ad Hoc Programs	32,200	X	X
Purchased Services	Funding for Photography and Video Production Services Needed to Support New CalOptima Health Initiatives	27,000	X	X
Purchased Services	Pre Employment Applicant Testing	25,000	X	X
Purchased Services	Consulting Services to Support Data Mapping for Directories and New Provider Data Platform	25,000	X	X
Purchased Services	Building Cleaning and Sanitization	24,000	X	X
Purchased Services	Health Screening	24,000	X	X
Purchased Services	Customization for Incentive Program Reporting, Annual Fee for Grantmaking Software	18,450	X	X
Purchased Services	Tax Form Processing Fees and Other General Purchased Services	15,500	X	X
Purchased Services	Destruction of Electronic Media	12,000	X	X
Purchased Services	Compensation System Subscription Fee	9,500	X	X
Purchased Services	Cyber Security Awareness Month	6,000	X	X
Purchased Services	Imaging Services	3,760	X	X
Purchased Services	General Services for Operations Management Support	1,200	X	X
	Total Non-Salary Operating Expenses	**54,554,814**		

Attachment B: Administrative Budget Details

	OneCare: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2023-24 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Vendor Application Support for Broker Agency Commission for Member Enrollment and Claims Pricing Solution	696,000	X	X
Other Operating Expenses	Member Outreach Activities and Promotional Items for Community Events	73,000	X	X
Other Operating Expenses	Subscriptions, Certifications and Professional Dues	44,525	X	X
Other Operating Expenses	Training and Seminars for Professional Development and Education	42,130	X	X
Other Operating Expenses	Food Services Allowances, as Needed, for Sponsoring Member and Provider Meetings, Conferences, Community Events, Compliance Week, and Department Training and Meeting	20,950	X	X
Other Operating Expenses	Promotional Items for Community Events, Sponsorships, Registration Fees and Venue Rental	20,000	X	X
Other Operating Expenses	Travel Expenses for Visits to Provider Offices, Presentations, Health Fairs, Community Events, Annual Audits and Conferences/Seminars	15,471	X	X
Other Operating Expenses	Office Supplies Needed for Everyday Department Operations	9,525	X	X
Other Operating Expenses	Marketing and Outreach Activities and Promotional Items for Various Events	6,600	X	X
Other Operating Expenses	Provider Education Event and Quarterly Provider Awards	6,200	X	X
Printing & Postage	Marketing Materials, Including Sales Brochures, Posters, Handouts and Other Member and Provider Oriented Materials and Postage	700,000	X	X
Printing & Postage	Maintenance of Enrolled Members (Printing, Fulfillment, Postage), Member Routine Annual and Quarterly Mailings, Other Related Printing and Postage Expenses	630,000	X	X
Printing & Postage	Printing of Enrollment Materials, Retainment Materials, Broker Agency Enrollment Kits, and Other Related Printing Expenses	112,250	X	X
Printing & Postage	Member and Provider Materials, Fulfillment and Other Printing Fees for Various Departments	50,000	X	X
Printing & Postage	Provider Directory Validation Forms, Annual Education and Attestations, Access and Availability Timely Access, Network Adequacy, Letter, Envelopes and Postage	16,200	X	X
Professional Fees	Annual Contract Bid for OneCare and Other Financial Consulting Services	410,000	X	X
Professional Fees	Medicare Consultants and Agency Services	250,000	X	X
Professional Fees	Medicare Data Validation Audit and Program Audit Engagement	180,000	X	X
Professional Fees	Annual Compliance Program Effectiveness (CPE) Audit	60,000	X	X
Purchased Services	Pharmacy Benefits Management	1,153,290	X	X
Purchased Services	Broker Agency Commission for Member Enrollment and Other Related Expenses	1,130,000	X	X
Purchased Services	Advertising and Media Buys (Newspapers, Magazines, Radio, Bus Shelter, Campaigns, Other Media)	500,000	X	X
Purchased Services	Language Interpretation, Face to Face Interpreter Services, Telephonic Interpreter and Video Interpreting Services, and Translation of Member Materials	192,000	X	X
Purchased Services	Member Chart Retrieval Services	135,000	X	X
Purchased Services	Claims Processing Through Automation Data Flow	56,000	X	X
Purchased Services	Member Experience Survey	25,000	X	X
	Total Non-Salary Operating Expenses	**6,534,141**		

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Attachment B: Administrative Budget Details

	PACE: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2023-24 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Software License and Support, Repairs and Maintenance of Minor Equipment, Building and Unforeseen Incidentals and Building Security Services	63,000	X	X
Other Operating Expenses	Outreach Events and Promotional Marketing Items to Help Elevate PACE Center and Support Program Enrollment and Expansion	14,700	X	X
Other Operating Expenses	Electricity, Gas, Water and Other Related Expenses	10,350	X	X
Other Operating Expenses	General Liability, Property, Earthquake and Other Insurance Fees	7,560	X	X
Other Operating Expenses	Food Services Allowances for Sponsoring, Enrollment and Retention Events, Member and Provider Meetings, Conferences and Trainings	3,225	X	X
Other Operating Expenses	Staff Development Training (Registration Fees, Travel, Accommodations, Incidentals)	3,024	X	X
Other Operating Expenses	Property Tax Assessment	2,070	X	X
Other Operating Expenses	Subscriptions, Membership, Registration for Dietetic and Other Discipline Specific Memberships	1,431	X	X
Other Operating Expenses	Minor Equipment and Supplies (Kitchen, Rehab, Social Day, Staff Break Room, Clinic/Rehab Equipment)	1,422	X	X
Other Operating Expenses	Office Supplies for Staff	1,080	X	X
Other Operating Expenses	Staff Travel and Mileage for Home Visits, Marketing, Conferences and Enrollment	630	X	X
Printing & Postage	Participant Newsletter, Typesetting for Translated Materials, Printing, Fulfillment and Postage Costs for Direct Mail Campaign, Marketing Materials and Other Printing Expenses	49,350	X	X
Professional Fees	Part D Actuarial Services and Other Financial Consulting Fees	58,845	X	X
Purchased Services	Advertising (Radio, Television, Print, Outdoor, Digital and Other Mediums) to Promote and Support Enrollment and Participation	90,000	X	X
Purchased Services	Health Outcomes and Satisfaction Surveys, Encounter Data File Formatting, Sterilization of Medical Equipment, Provider Communication, Appointment Services, Telehealth Support Services, Medical Equipment Calibration and Other Related Expenses	9,495	X	X
	Total Non-Salary Operating Expenses	**316,182**		

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	MSSP: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2023-24 Input**	**Authorization**	**Appropriation**
Professional Fees	Annual Finance Audit	16,000	X	X
Other Operating Expenses	Regular Home Visits with Members for Field Staff and Quarterly Director Site Meeting	11,000	X	X
Other Operating Expenses	Routine Office Supplies for Field and Office Staff	800	X	X
Other Operating Expenses	Cell Phones and Data Plans for Field Staff and Management Team Who Complete Onsite Home Assessments	20,000	X	X
Other Operating Expenses	Professional Certifications	5,500	X	X
Other Operating Expenses	Professional Development and Education	2,000	X	X
Other Operating Expenses	Information Management Software for Long Term Care	50,000	X	X
	Total Non-Salary Operating Expenses	**105,300**		

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	Facilities: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2023-24 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Electricity	561,706	X	X
Other Operating Expenses	Janitorial Night Contract	411,939	X	X
Other Operating Expenses	Property, Liability and Earthquake Insurance	408,000	X	X
Other Operating Expenses	Security Contract	343,198	X	X
Other Operating Expenses	Engineering Contract	218,431	X	X
Other Operating Expenses	Other Repair and Maintenance (Signage, Steam Cleaning, Roof, Locksmith, Pest Control Contract, Lobby Door, CAM, Other Maintenance)	161,424	X	X
Other Operating Expenses	Janitorial Day Contract	153,527	X	X
Other Operating Expenses	Plumbing	126,540	X	X
Other Operating Expenses	Janitorial Supplies	104,400	X	X
Other Operating Expenses	HVAC Miscellaneous	96,648	X	X
Other Operating Expenses	Electrical Repairs and Supplies	83,750	X	X
Other Operating Expenses	Gas	75,720	X	X
Other Operating Expenses	Exterior Landscape Contract	48,935	X	X
Other Operating Expenses	Other Fire/Life Safety Expenses (Phone, Emergency Generator, Other Expenses)	35,933	X	X
Other Operating Expenses	Security Equipment and Maintenance	32,024	X	X
Other Operating Expenses	Windows	30,072	X	X
Other Operating Expenses	Landscape Extras	29,580	X	X
Other Operating Expenses	Elevator Maintenance Contract	29,259	X	X
Other Operating Expenses	Water - Building	25,727	X	X
Other Operating Expenses	HVAC Maintenance Contract	24,707	X	X
Other Operating Expenses	Painting	23,700	X	X
Other Operating Expenses	Property Tax Assessments	20,811	X	X
Other Operating Expenses	Walls/Ceilings/Floors/Sidewalks/Railings	19,380	X	X
Other Operating Expenses	Water Treatment	17,458	X	X
Other Operating Expenses	Trash	10,344	X	X
Other Operating Expenses	Parking Lot Maintenance and Sweeping	10,116	X	X
Other Operating Expenses	Door Maintenance and Repair	6,600	X	X
Purchased Services	Property Management, Administration Fee and Other Related Expenses	262,477	X	X
	Total Non-Salary Operating Expenses	**3,372,405**		

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Attachment B: Administrative Budget Details

	Facilities: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2023-24 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Security Contract	288,180	X	X
Other Operating Expenses	Electricity	274,551	X	X
Other Operating Expenses	Janitorial Night Contract	212,160	X	X
Other Operating Expenses	Property, Liability and Earthquake Insurance	121,087	X	X
Other Operating Expenses	Other Repair and Maintenance (Signage, Steam Cleaning, Roof, Locksmith, Pest Control Contract, Lobby Door, CAM, Other Maintenance)	86,979	X	X
Other Operating Expenses	Engineering Contract	77,100	X	X
Other Operating Expenses	Electrical Repairs and Supplies	44,600	X	X
Other Operating Expenses	Janitorial Day Contract	38,147	X	X
Other Operating Expenses	Plumbing	29,200	X	X
Other Operating Expenses	HVAC Miscellaneous	26,285	X	X
Other Operating Expenses	Exterior Landscape Contract	25,980	X	X
Other Operating Expenses	Walls/Ceilings/Floors/Sidewalks/Railings	22,132	X	X
Other Operating Expenses	Painting	20,475	X	X
Other Operating Expenses	Door Maintenance and Repair	20,400	X	X
Other Operating Expenses	HVAC Maintenance Contract	20,356	X	X
Other Operating Expenses	Parking Lot Maintenance and Sweeping	19,062	X	X
Other Operating Expenses	Janitorial Supplies	18,000	X	X
Other Operating Expenses	Windows	15,810	X	X
Other Operating Expenses	Landscape Extras	14,800	X	X
Other Operating Expenses	Water - Building	12,800	X	X
Other Operating Expenses	Security Equipment and Maintenance	12,460	X	X
Other Operating Expenses	Other Fire/Life Safety Expenses (Phone, Emergency Generator, Other Expenses)	11,215	X	X
Other Operating Expenses	Elevator Maintenance Contract	9,600	X	X
Other Operating Expenses	Trash	6,000	X	X
Other Operating Expenses	Water Treatment	5,376	X	X
Purchased Services	Property Management, Administration Fee and Other Related Expenses	85,516	X	X
	Total Non-Salary Operating Expenses	**1,518,271**		

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Attachment B1: Digital Transformation Administrative Budget Details

	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2023-24 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Software Licenses Pertaining to Capital Projects	4,014,000	X	X
Other Operating Expenses	Validation and Submission of Encounter Data to Meet Regulatory Agency Requirements	2,958,003	X	X
Other Operating Expenses	Cloud Government and Commercial Subscription	1,600,000	X	X
Other Operating Expenses	SOC (Security Operation Center) as a Service	1,576,000	X	X
Other Operating Expenses	Cybersecurity Asset Management, Data Masking and Virtual Database License and Support	850,000	X	X
Other Operating Expenses	Provider Database Access Controls and Security Monitoring	500,000	X	X
Other Operating Expenses	Robotic Process Automation and Provider Life Cycle Data Management Software	475,000	X	X
Other Operating Expenses	Application Software Maintenance - IT Development Tools (Data Modeling, Architecture, Technical Libraries, Documentation, Technical Frameworks, Electronic Data Interchange, Software Development Testing)	419,000	X	X
Other Operating Expenses	Data Protection and Digital Forensics and Incident Services	300,000	X	X
Other Operating Expenses	End Point Protection/Detection/Response Services	260,000	X	X
Other Operating Expenses	Zero Trust Network Architecture	250,000	X	X
Other Operating Expenses	Asset Management Application for Visibility to Systems	250,000	X	X
Other Operating Expenses	Provider Cloud Data Loss Prevention and Internet Access Protection	225,000	X	X
Other Operating Expenses	Identity and Access Management	200,000	X	X
Other Operating Expenses	Privileged and Identity Access Management	200,000	X	X
Other Operating Expenses	Cloud Workload Protection and Various Subscriptions	131,000	X	X
Other Operating Expenses	Professional Dues and Member Fees for Various Professional Associations	50,000	X	X
Other Operating Expenses	Training & Seminar - System and Software Update Training - Process Improvement Training - Staff Training to Stay Current with Industry Changes - Local Annual Conferences for Collaboration and Learning	48,500	X	X
Professional Fees	Digital Transformation Consulting Services in Various Areas	1,000,000	X	X
Professional Fees	Consulting Services for Website and Portal Development and Quality Assurance Support for Testing	540,000	X	X
Professional Fees	Consulting Services for Cloud-Based Subscription Service and Autopilot Implementation, Converting Data Engine to Cloud Platform, and Data Masking	325,000	X	X
Professional Fees	Consulting Services for Providing Industry Specific and Best Practices in Utilizing Enterprise Architecture and Artificial Intelligence	240,000	X	X
Purchased Services	Vendor Supported Robotic Process Automation Functions - Development and Training	1,000,000	X	X
Purchased Services	Batch Modeling Solution, Annual Support Provider Data Management Integrated System	650,000	X	X
Purchased Services	Support for Web and Portal Development Services	150,000	X	X
Purchased Services	Managed Service Provider for Managing and Monitoring Ongoing Cloud Costs	60,000	X	X
	Total Non-Salary Operating Expenses	**18,271,503**		

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

19. Approval of the CalOptima Health Fiscal Year 2023-24 Routine Capital and Digital Transformation Year Two Capital Budgets

Contact

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

Recommended Actions

1. Approve the CalOptima Health Fiscal Year 2023-24 Routine Capital and Digital Transformation Year Two Capital Budgets; and
2. Authorize the expenditures and appropriate the funds for the following items, which shall be procured in accordance with CalOptima Health Board-approved policies:
    a. Attachment A: Fiscal Year 2023-24 Routine Capital Budget by Project; and
    b. Attachment A1: Fiscal Year 2023-24 Digital Transformation Year Two Capital Budget by Project.

Background

As of March 31, 2023, CalOptima Health recorded gross capital assets of $136.8 million in the 505 Building, 500 Building, building improvements, furniture, equipment, and information systems, including Digital Transformation projects. To account for these fixed assets wearing out over time, staff has charged against the costs of these assets an accumulated depreciation totaling $69.6 million. The resulting net book value of these fixed assets was $67.1 million, as of March 31, 2023.

Staff will record capital assets acquired in Fiscal Year (FY) 2023-24 at acquisition cost and will depreciate the value on a straight-line basis over their estimated useful lives as follows:

- Five (5) years for office furniture and fixtures;
- Three (3) years for computer equipment and software;
- The lesser of fifteen (15) years or remaining term of lease for leasehold improvements; and
- Ten (10) to twenty (20) years, based on components, for building improvements.

Prior Board of Directors (Board)-approved Routine Capital Budgets were $13.7 million in FY 2022-23, and $14.7 million in FY 2021-22. On June 2, 2022, the Board approved $34.2 million for the Digital Transformation Capital Budget in FY 2022-23, year one of the Digital Transformation and Workplace Modernization Strategy (DTS).

Pursuant to CalOptima Health policies GA.3202: CalOptima Health Signature Authority, GA.5002: Purchasing, and GA.5003: Budget Approval and Budget Reallocation, the Board's approval of the budget authorizes the expenditure for the item and appropriates the funds requested without further Board action to the extent the Board has or is, as indicated in the budget attachments, delegating authority to management.

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Discussion

A. FY 2023-24 Routine Capital Budget

Management proposes a Routine Capital Budget of $14.7 million for FY 2023-24 with four (4) asset categories. More detailed information is provided in Attachment A: Fiscal Year 2023-24 Routine Capital Budget by Project.

Asset Category	FY 2023-24 Budget	% of Total
1. Information Technology Services (ITS)	$1,705,500	11.6%
2. 505 Building Improvements	$3,568,000	24.2%
3. 500 Building Improvements	$8,850,500	60.0%
4. PACE	$617,000	4.2%
Total:	**$14,741,000**	**100%***

* Totals may not add up due to rounding.

FY 2023-24 Routine Capital Budget by Asset Category

1. Information Technology Services: ITS represents $1.7 million or 11.6% of the Routine Capital Budget. This category includes funding for hardware, software, and professional fees related to the implementation of multiple systems upgrades. These upgrades are necessary to support internal operations and to ensure compliance with state and federal requirements.

Capital Project Type	FY 2023-24 Budget	% of Total
Infrastructure	$1,215,500	71.3%
Applications Management	$120,000	7.0%
Cyber Security	$370,000	21.7%
Total:	**$1,705,500**	**100%***

* Totals may not add up due to rounding.

2. 505 Building Improvements: 505 Building Improvements represent $3.6 million or 24.2% of the Routine Capital Budget.

Capital Project Type	FY 2023-24 Budget	% of Total
Mustering System	$1,000,000	28.0%
Front/Back Entrance Door Upgrade	$550,000	15.4%
Office Tenant Improvements	$400,000	11.2%
Furniture Upgrades	$300,000	8.4%
Building Exterior Signage Upgrade	$280,000	7.8%
Audio Visual Enhancements	$225,000	6.3%
In Road Warning Light Crosswalk	$200,000	5.6%
Touchless Faucets	$183,000	5.1%

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Capital Project Type	FY 2023-24 Budget	% of Total
Capital Lease Copiers	$110,000	3.1%
Fire Panel Annunciator	$75,000	2.1%
Electric Car Charging Station	$68,000	1.9%
CalOptima Health New Vehicle	$65,000	1.8%
HVAC Equipment Replacement	$60,000	1.7%
Electric Water Heater	$18,500	0.5%
Security Desk Alarm Annunciator	$18,500	0.5%
Digital Directory in Lobby	$15,000	0.4%
Total:	**$3,568,000**	**100%***

* Totals may not add up due to rounding.

3. 500 Building Improvements: 500 Building Improvements represent $8.9 million or 60.0% of the Routine Capital Budget. Estimates are based on the potential availability of vacant space in FY 2023-24.

Capital Project Type	FY 2023-24 Budget	% of Total
Tenant Improvements	$4,200,000	47.5%
Technology Updates	$2,100,000	23.7%
Office Furniture and Other Equipment	$1,370,000	15.5%
HVAC Equipment Replacement	$650,000	7.3%
Building Exterior Signage	$200,000	2.3%
Parking Lot Security - Blue Light	$200,000	2.3%
New Fire Control Panel	$50,000	0.6%
Building Security Cameras	$40,500	0.5%
Backflow Relocation	$25,000	0.3%
Touchless Faucets in Common Area Restrooms	$15,000	0.2%
Total:	**$8,850,500**	**100%***

* Totals may not add up due to rounding.

4. Program for All-Inclusive Care for the Elderly (PACE): The remaining portion of $617,000 or 4.2% of the Routine Capital Budget is for capital expenditures at the PACE Center.

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Capital Project Type	FY 2023-24 Budget	% of Total
Electronic Medical Record Upgrade	$500,000	81.0%
Flooring Upgrade	$100,000	16.2%
Chemical Dishwasher	$8,500	1.4%
Building Blinds Upgrade	$8,500	1.4%
Total:	**$617,000**	**100%***

* Totals may not add up due to rounding.

B. FY 2023-24 Digital Transformation Year Two Capital Budget

On March 17, 2022, the Board authorized a three-year Digital Transformation and Workplace Modernization Strategy and created a $100 million restricted reserve to fund digital transformation efforts. As of March 31, 2023, the updated Digital Transformation Year One Capital Budget is $36.3 million. The Digital Transformation Year Two Capital Budget includes new DTS capital projects or requests for additional resources for capital projects previously approved in the prior year.

Management proposes a Digital Transformation Year Two Capital Budget of $21.0 million from the restricted reserve for capital projects during the second year of implementation. More detailed information is provided in Attachment A1: Fiscal Year 2023-24 Digital Transformation Year Two Capital Budget by Project.

Capital Project Type	FY 2023-24 Budget	% of Total
Infrastructure	$3,387,000	16.1%
Applications Management	$11,750,000	56.0%
Enterprise Data and Systems Integration	$1,550,000	7.4%
Applications Development	$3,300,000	15.7%
Enterprise Architecture	$1,000,000	4.8%
Total:	**$20,987,000**	**100%**

Fiscal Impact

Investment in the FY 2023-24 Routine Capital and Digital Transformation Year Two Capital Budgets will reduce CalOptima Health's investment principal by $14,741,000 and $20,987,000, respectively. Depreciation expenses for Capital Budget projects are reflected in the proposed FY 2023-24 CalOptima Health Operating Budget.

Rationale for Recommendation

The FY 2023-24 Routine Capital and Digital Transformation Year Two Capital Budgets will enable necessary system upgrades, enhance operational efficiencies, support CalOptima Health's mission and vision statements and strategic plan, comply with federal and state requirements, and improve and upgrade the 505 Building, 500 Building, and PACE Center.

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Concurrence
Troy Szabo, Outside General Counsel, Kennaday Leavitt
Finance and Audit Committee

Attachments
1. Fiscal Year 2023-24 Routine Capital Budget Presentation
2. Attachment A: Fiscal Year 2023-24 Routine Capital Budget by Project
3. Attachment A1: Fiscal Year 2023-24 Digital Transformation Year Two Capital Budget by Project

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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Agenda

- FY 2023-24 Routine Capital Budget
  - Information Technology Services
  - 505 Building Improvements
  - 500 Building Improvements
  - PACE
- FY 2023-24 Digital Transformation Year Two Capital Budget
- Recommended Actions

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FY 2023-24 Budget (Capital Budget Funded)
ROUTINE CAPITAL

$ 14,741,000

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FY 2023-24 Budget (Reserves Funded)
DIGITAL TRANSFORMATION CAPITAL

$ 20,987,000

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FY 2023-24 Budget
TOTAL CAPITAL

$35,728,000

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FY 2023-24 Routine Capital Budget

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FY 2023-24 Routine Capital Budget

Asset Category	FY 2023-24 Budget	% of Total
Information Technology Services (ITS)	$1,705,500	11.6%
505 Building Improvements	$3,568,000	24.2%
500 Building Improvements	$8,850,500	60.0%
PACE	$617,000	4.2%
Total:	**$14,741,000**	**100.0%**

- Departments submit requests for capital projects based on strategic and operational needs
- ITS Department reviews technology requests

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Information Technology Services (ITS)

Capital Project Type	FY 2023-24 Budget
Infrastructure (e.g., Web Monitoring Solution, Conference Room Video/Audio Enhancement, Outages and Incident Windows Toolset)	$1,215,500
Applications Management (e.g., Business Continuity Plan, Project Portfolio Management)	$120,000
Cyber Security (e.g., Security Incident Event Monitoring)	$370,000
Total:	**$1,705,500**

- Represents nearly 11.6% of the Routine Capital Budget
- Addresses information technology infrastructure needs to support current internal operations
- Ensures compliance with state and federal requirements

Note: Project details can be found in Attachment A: Fiscal Year 2023-24 Capital Budget by Project

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505 Building Improvements

Capital Project Type	FY 2023-24 Budget
Mustering System	$1,000,000
Front/Back Entrance Door Upgrade	$550,000
Office Tenant Improvements	$400,000
Furniture Upgrades	$300,000
Building Exterior Signage Upgrade	$280,000
Audio Visual Enhancements	$225,000
In Road Warning Light Crosswalk	$200,000
Touchless Faucets	$183,000
Capital Lease Copiers	$110,000
Fire Panel Annunciator	$75,000
Electric Car Charging Station	$68,000
CalOptima Health New Vehicle	$65,000
HVAC Equipment Replacement	$60,000
Electric Water Heater	$18,500
Security Desk Alarm Annunciator	$18,500
Digital Directory in Lobby	$15,000
Total:	**$3,568,000**

- Represents 24.2% of the Routine Capital Budget

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500 Building Improvements

Capital Project Type	FY 2023-24 Budget
Tenant Improvements	$4,200,000
Technology Updates	$2,100,000
Office Furniture and Other Equipment	$1,370,000
HVAC Equipment Replacement	$650,000
Building Exterior Signage	$200,000
Parking Lot Security - Blue Light	$200,000
New Fire Control Panel	$50,000
Building Security Cameras	$40,500
Backflow Relocation	$25,000
Touchless Faucets in Common Area Restrooms	$15,000
Total:	**$8,850,500**

- Represents 60.0% of the Routine Capital Budget
- Estimates based on potential availability of vacant space in FY 2023-24

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PACE

Capital Project Type	FY 2023-24 Budget
Electronic Medical Record Upgrade	$500,000
Flooring Upgrade	$100,000
Chemical Dishwasher	$8,500
Building Blinds Upgrade	$8,500
Total:	**$617,000**

- Represents 4.2% of the Routine Capital Budget

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FY 2023-24 Digital Transformation Year Two Capital Budget

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FY 2023-24 Digital Transformation Year Two Capital Budget ($100 million total reserve)

Capital Project Type	FY 2023-24 Budget
Infrastructure (e.g., Network Bandwidth Upgrade, Internet Bandwidth Upgrade, Customer Service Virtual Agent Support)	$3,387,000
Applications Management (e.g., Customer Relationship Management System, Care Management System Enhancement, Healthcare Enterprise Management Platform)	$11,750,000
Enterprise Data and Systems Integration (e.g., Member Master Data Management, Data Warehouse Architecture Enhancement)	$1,550,000
Applications Development (e.g., Human Resources Capital Management Solution Software, Mobile Application Development Testing Tool)	$3,300,000
Enterprise Architecture (e.g., Provider Virtual Agent Support)	$1,000,000
Total:	**$20,987,000**

- 3/17/22: Board authorized a three-year strategy and created a $100 million restricted reserve to fund digital transformation efforts
- Proposed budget reflects capital projects during Year Two of implementation
- For details, see Attachment A1: Fiscal Year 2023-24 Digital Transformation Year Two Capital Budget by Project

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Recommended Actions

- Approve the CalOptima Health Fiscal Year 2023-24 Routine Capital and Digital Transformation Year Two Capital Budgets

- Authorize the expenditures and appropriate the funds for the following items, which shall be procured in accordance with CalOptima Health Board-approved policies:
  - Attachment A: Fiscal Year 2023-24 Routine Capital Budget by Project
  - Attachment A1: Fiscal Year 2023-24 Digital Transformation Year Two Capital Budget by Project

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Attachment A: Fiscal Year 2023-24 Routine Capital Budget by Project

INFRASTRUCTURE		TOTAL CAPITAL
Web Monitoring Solution Tool		419,000
Managed Service Provider Support		350,000
Test Environment for Database High Availability		300,000
Conference Room Video/Audio Enhancement		60,000
Event Management and Escalation Toolset		50,000
Outages and Incident Windows Toolset		25,000
Patch Management Solution		11,500
TOTAL INFRASTRUCTURE	**$**	**1,215,500**

APPLICATION MANAGEMENT		TOTAL CAPITAL
Business Continuity Plan		70,000
Project Portfolio Management		50,000
TOTAL APPLICATION MANAGEMENT	**$**	**120,000**

CYBER SECURITY		TOTAL CAPITAL
Security Incident Event Monitoring		250,000
Electronic Patient Health Information Access Database Monitoring		120,000
TOTAL CYBER SECURITY	**$**	**370,000**

505 BUILDING IMPROVEMENTS		TOTAL CAPITAL
Mustering System		1,000,000
Front/Back Entrance Door Upgrade		550,000
Office Tenant Improvements		400,000
Furniture Upgrades		300,000
Building Exterior Signage Upgrade		280,000
Audio Visual Enhancements		225,000
In Road Warning Light Crosswalk		200,000
Touchless Faucets		183,000
Capital Lease Copiers		110,000
Fire Panel Annunciator		75,000
Electric Car Charging Station		68,000
CalOptima Health New Vehicle		65,000
HVAC Equipment Replacement		60,000
Electric Water Heater		18,500
Security Desk Alarm Annunciator		18,500
Digital Directory in Lobby		15,000
TOTAL 505 BUILDING IMPROVEMENTS	**$**	**3,568,000**

500 BUILDING IMPROVEMENTS		TOTAL CAPITAL
Tenant Improvements		4,200,000
Technology Updates		2,100,000
Office Furniture and Other Equipment		1,370,000
HVAC Equipment Replacement		650,000
Building Exterior Signage		200,000
Parking Lot Security - Blue Light		200,000
New Fire Control Panel		50,000
Building Security Cameras		40,500
Backflow Relocation		25,000
Touchless Faucets in Common Area Restrooms		15,000
TOTAL 500 BUILDING IMPROVEMENTS	**$**	**8,850,500**

PACE		TOTAL CAPITAL
Electronic Medical Record Upgrade		500,000
Flooring Upgrade		100,000
Chemical Dishwasher		8,500
Building Blinds Upgrade		8,500
TOTAL PACE	**$**	**617,000**

TOTAL FY 2023-24 ROUTINE CAPITAL BUDGET	**$**	**14,741,000**

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Attachment A1: Fiscal Year 2023-24 Digital Transformation Year Two Capital Budget by Project

INFRASTRUCTURE		TOTAL CAPITAL
Network Bandwidth Upgrade for All Sites (Wide Area Network)		2,040,000
Internet Bandwidth Upgrade for All Sites		546,000
Upgrade PACE Internet Networks		463,000
Upgrade PACE Wide Area Networks		238,000
Customer Service Virtual Agent Support		100,000
TOTAL INFRASTRUCTURE	**$**	**3,387,000**

APPLICATIONS MANAGEMENT		TOTAL CAPITAL
Orange County - Health Information Exchange Coalition Data Sharing		5,000,000
Integrated Provider Data Management, Contract Management and Credentialing Systems		2,500,000
Customer Relationship Management System		2,000,000
Orange County - Health Information Exchange Participation		500,000
Orange County - Health Information Exchange Hospital Data Sharing		500,000
System Development Enhancement for CalAIM		400,000
Clinical Data Sets Quality Assurance & Data Aggregator Validation		250,000
Web Based Services for Core Administrative System		250,000
Care Management System Enhancement		150,000
Provider Portal Integration with Clinical Guidelines		75,000
Electronic Cloud Based Fax Solution		75,000
Healthcare Enterprise Management Platform		50,000
TOTAL APPLICATIONS MANAGEMENT	**$**	**11,750,000**

ENTERPRISE DATA AND SYSTEMS INTEGRATION		TOTAL CAPITAL
Member Master Data Management		600,000
Assessments for Social Determinants of Health		400,000
Migration of Operational Reportng/Analytics to the Cloud		300,000
Data Warehouse Architecture Enhancement		250,000
TOTAL ENTERPRISE DATA AND SYSTEMS INTEGRATION	**$**	**1,550,000**

APPLICATIONS DEVELOPMENT		TOTAL CAPITAL
Migration Website Content Management System to the Cloud		1,500,000
Digital Transformation Strategy Planning and Execution Support		900,000
Artificial Intelligence/Machine Learning Tools to Turn Data into Information		200,000
Human Resources Capital Management Solution Software		200,000
Migration of Provider and Member Portals to the Cloud		150,000
Human Resources Electronic Record System		150,000
Software Quality Assurance / Testing Tools		100,000
Migration of Programmers Development Environment to Cloud		75,000
Mobile Application Development Testing Tool		25,000
TOTAL APPLICATIONS DEVELOPMENT	**$**	**3,300,000**

ENTERPRISE ARCHITECTURE		TOTAL CAPITAL
Data Conversion Using Artificial Intelligence/Machine Learning Tools		700,000
Provider Virtual Agent Support		300,000
TOTAL ENTERPRISE ARCHITECTURE	**$**	**1,000,000**

TOTAL FY 2023-24 DIGITAL TRANSFORMATION YEAR TWO CAPITAL BUDGET	**$**	**20,987,000**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
20. Approve Actions Related to the Housing and Homelessness Incentive Program

Contacts
Kelly Bruno Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions
1. Approve the new Housing and Homelessness Incentive Program (HHIP) priority area, Innovation and Implementation of Strategic Interventions, including system change projects.
2. Authorize CalOptima Health staff to develop scopes of work to be used in requests for proposals, notices of funding opportunities, or direct contracts for defined programs that fall under one of the following initiatives within the priority areas:
    a. Capital Projects;
    b. Equity Grants Programs Serving Underrepresented Populations; or
    c. System Change projects, including Nonprofit Healthcare Academy.
3. Approve allocation of up to $22.3 million in HHIP funds earned through the Submission 1 report from the California Department of Health Care Services (DHCS) pursuant to Exhibit 1: HHIP Allocation and Awards.
4. Allocate up to $22.3 million from existing reserves to match the DHCS funds and provide additional support for HHIP priorities pursuant to Exhibit 1: HHIP Allocation and Awards.
5. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background
With consideration of the broad investment strategies presented to CalOptima Health's Board of Directors (Board) in September 2022, including a reallocation of $40.1 million for HHIP homeless initiatives and submission of the final investment plan to DHCS, staff received Board approval in December 2022 to proceed with development of a notice of funding opportunities. Three funding areas were identified, including Capital Projects, Infrastructure Grants and Equity Grants.

In March 2023, the Board approved another round of NOFO focused on $19.25 million in capital projects (*i.e.*, remaining $6.65 million from the January 2023 NOFO and $12.60 million that was earned through submission of the HHIP local homelessness plan and investment plan).

The March NOFO resulted in $29.9 million in funding for 29 community organizations to expand services for members experiencing homelessness, including permanent supportive housing.

Discussion
On March 10, 2023, staff submitted HHIP Submission 1 to DHCS, through which CalOptima Health has earned approximately $22.28 million for achieving program metrics. With these funds plus additional

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requested reserve funds, CalOptima Health expects to initiate additional notice of funding opportunities and make targeted investments, as outlined in Exhibit 1.

Equity Grants for Programs Serving Underrepresented Population: Staff requests $1 million to fund equity grants. In an effort to help increase capacity and reach among community-based organizations, CalOptima Health staff propose another round of equity grants for smaller organizations. Eligible organizations include those with operating budgets of $5 million or less and whose focus is on addressing the unique issues that impact underrepresented populations experiencing homelessness.

Capital Projects: To further expand Priority 3, staff members are currently requesting an additional $10.75 million from the HHIP Submission 1 funding from DHCS. To further this HHIP initiative, staff requests the Board to commit $22.3 million from existing reserves. Combined with the previously Board-allocated amount of $19.25 million, the total funding available for this capital funding opportunity is $52.3 million. More details are available in Exhibit 1. This community investment is expected to positively impact and facilitate the development of housing options for people experiencing homelessness throughout the county, one of the greatest identified barriers to addressing the homelessness crisis.

Priority 4, Innovation and Implementation of Strategic Interventions including Nonprofit Healthcare Academy: Staff are looking at investments that will drive innovation and promote lasting system change and are requesting a portion of HHIP funds from Submission 1 be allocated to projects that meet these criteria under new Priority 4. Systems change work will be undertaken to improve the county's continuum of services for people experiencing homelessness. These projects will adopt intentional strategies to tackle the county-wide, complex, and dynamic issues at play in best meeting the needs of members experiencing homelessness.

Additionally, it is also recognized that capacity building in the homeless services sector and broader CalAIM sustainability hinges on organizations' abilities to partner with the healthcare sector, which is why staff would like to administer an RFP to identify a vendor who can design and facilitate a multi-session nonprofit healthcare academy. Organizations selected to participate in the academy will receive technical assistance and education on a variety of topics, such as grant writing, in an attempt to position them to better partner with the healthcare sector.

Update on HHIP State Revenue: The following table provides the total amount of HHIP funding CalOptima Health has earned to date, with an update on the projected earnable HHIP funding for the remainder of the program. Staff will return to the Board with additional recommendations on the remaining unallocated and unused HHIP budget or in the event there are adjustments to the forecasted HHIP funding levels from DHCS.

HHIP Funding from DHCS	**Estimated Amount* (in millions)**
Funding received from Local Homelessness Plan submission (received November 2022)	$4.2
Funding received from Investment Plan submission (received January 2023)	$8.4
Funding earned related to Submission 1 (to be received June 2023)	$22.3

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HHIP Funding from DHCS	Estimated Amount* (in millions)
Maximum earnable funding related to Submission 2 (due December 2023; funds expected March 2024)	$41.9
Total (in millions)	**$76.8**

*Reflects the maximum earnable amount by CalOptima Health; final earned amount may change depending on plan performance on program measures.

Fiscal Impact
The recommended action to allocate up to $22.3 million will be funded from existing reserves.

The allocation of approximately $22.28 million in funding from DHCS has no net fiscal impact on CalOptima Health's Fiscal Year 2022-23 Operating Budget. The increased amounts attributable to HHIP will be used to fund Equity Grants for Program Serving Underrepresented Populations (Priority 2), Capital Projects (Priority 3) and System Change projects, including Nonprofit Healthcare Academy (Priority 4).

CalOptima Health reserves the right to adjust funding from vendors or 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 measures.

Rationale for Recommendation
Funding these programs and projects will aid CalOptima Health in meeting HHIP measures through which CalOptima Health can receive additional funding that will enable even more investments in the community to address homelessness. Staff will bring additional recommendations to the Board for review and approval in the future.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Exhibit 1: Housing and Homelessness Incentive Program Allocation and Awards

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Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
12/1/2022	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$36.5 million
3/2/2023	Approve Actions Related to the Housing and Homelessness Incentive Program	-	

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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Exhibit 1: Housing and Homelessness Incentive Program Allocation and Awards

HHIP Priority Areas and Initiatives	Funding Allocation			Amounts for NOFO/RFP			Balance Available
	Allocation 1 (BOD 3/2/23)	Allocation 2 (Proposed BOD Action 6/1/23)	Total Allocation	Awards from NOFO Round 1 (BOD 3/2/23) or Contracted	Awards from NOFO Round 2/RFP (Pending Future BOD Approval)	Total Awards from NOFO/RFP	
Priority 1: Delivery of services and member engagement	3.60		**3.60**	3.00		**3.00**	0.60
Priority 2: Infrastructure to coordinate and meet member housing needs							
Equity Grants for Programs Serving Underrepresented Populations	3.00	1.00	**4.00**	3.00	1.00	**4.00**	0.00
Infrastructure Projects	5.83	0.00	**5.83**	5.83	0.00	**5.83**	0.00
Priority 3: Partnerships and capacity to support referrals for services							
Capital Projects*	40.25	33.05	**73.30**	21.00	52.30	**73.30**	0.00
Priority 4: Innovation and implementation of strategic interventions							
System Change Projects		10.18	**10.18**		10.18	**10.18**	0.00
Non-profit Healthcare Academy		0.35	**0.35**		0.35	**0.35**	0.00
Total	**52.68**	**44.58**	**97.26**	**32.83**	**63.83**	**96.66**	**0.60**

Board Actions:

9/1/22: Initial $40.1 million reallocation from CalOptima Health Homeless Health Initiative reserve
3/2/23: $12.6 million from DHCS HHIP funding (Local Homelessness Plan and Investment Plan submissions)
Anticipated 6/1/23: $22.3 million from DHCS HHIP funding (Submission 1 Report)

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

21. Approve Actions Related to Wellness Prevention Foundation, dba Wellness & Prevention Center *allcove*™ South Orange County Mental Health Youth Center.

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 to develop and execute a grant agreement for a four-year term with the Wellness & Prevention Foundation, dba Wellness & Prevention Center (WPC), no earlier than July 1, 2023, to support the *allcove*™ South Orange County mental health youth center;
2. Authorize unbudgeted expenditures in an amount up to $2.7 million from existing reserves to fund the grant agreement with WPC; and
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background

There is a national mental health crisis. In particular, Orange County youth have been greatly impacted from the losses and impacts from COVID-19 as well as the impact of social media. According to the 28th Annual Report on the Conditions of Children in Orange County: (1) suicide is the second leading cause of death for Orange County (OC) 10-19-year-olds; (2) students are more likely to experience chronic sadness or hopeless feelings compared to 2011-2013, increasing 13.4% for 11th, 7.9% for 7th and 4.2% for 9th graders; and (3) in 2017-2019, an estimated 15% of 9th and 11th graders seriously considered attempting suicide in the previous year. This crisis is further aggravated by the mental health workforce shortage. It requires new thinking and approaches to overcome this crisis.

The Mental Health Service Oversight and Accountability Commission (MHSOAC) issued a request for applications to award $2,000,000 to five separate *allcove*™ projects. In May 2020, MHSOAC announced that grants would be awarded to five projects across California, including two projects in Los Angeles County, and one project in each of San Mateo County, Sacramento County, and Orange County. The Stanford Center for Youth Mental Health and Wellbeing team that created an *allcove*™ model was awarded the technical assistance (TA) contract establishing the Stanford Central *allcove*™ Team (CAT). For Orange County, the University of California, Irvine (UCI) and the WPC responded to the competitive request for applications and received $2,000,000 in funding to help launch the first *allcove*™ South Orange County (South OC) mental health youth center.

The *allcove*™ model offers an integrated and holistic approach for the delivery of services for youth (ages 12-25) with mild-to-moderate needs. The core service streams of *allcove*™ include mental health care, physical health care, substance misuse support, youth peer and family support, and supported

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education and employment. Every *allcove*^{TM} center is guided by an active Youth Advisory Group (YAG), composed of young people from the local community who represent diversity in race, ethnicity, gender, sexual orientation, lived experience, ability, and socioeconomic status. An *allcove*^{TM} YAG's goal is to ensure that youth voice and experience is included in the development and services of the center. In this approach, *allcove*^{TM} will offer case managers and peer support specialists to help coordinate care with the young person's physical health services, health home and other relevant providers of healthcare. If a young person visiting a center needs a higher-level behavioral health service, linkages are made to the county behavioral health system for more intensive intervention.

Discussion

CalOptima Health members, providers, and the Orange County Health Care Agency (OCHCA) continue to report a need for more mental health services in South OC. Granting the development of the first *allcove*^{TM} South OC mental health youth center would benefit and address the need for CalOptima Health's Medi-Cal youth beneficiaries in South OC. The mental health youth center can apply the whole-person care approach to Medi-Cal youth beneficiaries. The state grant funding of $2,000,000 leaves a shortfall of $2,687,528. CalOptima Health staff requests that the Board approve $2,687,528 to fund the first *allcove*^{TM} South OC mental health youth center for four years from fiscal year 2023-24 through fiscal year 2026-27. This time will allow UCI and WPC to develop a sustainable model and serve as future technical advisors for other community partners to develop and launch additional *allcove*^{TM} sites.

Staff will monitor and provide oversight of the grant funds following CalOptima Health Policy AA.1400p: Grant Management, which was approved during the CalOptima Health Board of Directors meeting on May 4, 2023. CalOptima Health will monitor and require *allcove*^{TM} to submit a quarterly project summary tied to measurable metrics. The list of metrics is located in Exhibit 1 - Required Reporting Elements.

CalOptima Health will also require progress reporting for activities related to sustainability quarterly for items #1-4 below. If during the time of the grant any services are able to move from grant money to billable services, funding will be adjusted to ensure no duplication:

1) By December 31, 2024, contract with and establish billing with CalOptima Health for any applicable CalAIM services.
2) By December 31, 2024, contract with and establish billing with CalOptima Health for mental health mild to moderate services
3) By June 30, 2026, establish other billing procedures with private health insurance.
4) Exploring additional streams for sustainability, including workforce enhancement training through UCI and Orange County Healthcare Agency Mental Health Services Act Prevention and Early Intervention funding.

Fiscal Impact

The recommended actions related to this grant are separate from the normal operating budget process. An appropriation of up to $2.7 million from existing reserves will fund the four-year grant agreement from July 1, 2023, through June 30, 2027.

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Rationale for Recommendation

CalOptima Health staff recommend proceeding with this action to support CalOptima Health's mission and vision for increased options and access for integrated mental health services for youth members in South OC.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. Exhibit 1

/s/ Michael Hunn *05/26/2023*

Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Wellness & Prevention Foundation dba Wellness & Prevention Center	700 Avenida Pico	San Clemente	CA	92673

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Exhibit 1

Grant Funding Breakdown:

UCI and WPC awarded MHSOAC State Grant Funding - $2,000,000 lasts through June 2026

Funding Categories	Estimated Amount
Personnel (6.1 FTEs) • Operating Agency ED • UCI - Dr. Stephen Schueller • Site Manager • Youth Outreach Specialist • Reception/Administrative Assistant • Clinical Psychology Postdoc • Mental Health Clinician PhD Trainee	$1,405,557
Pre-opening Office/General Administrative Costs • Furniture • Building improvements • Equipment • Travel • Rent ½ year	$413,360
UC Facilities and Administrative (F&A) Indirect Rate (10%)	$181,083
Total:	**$2,000,000**

CalOptima Health Non-MHSOAC Grant Funding: Fiscal Years 2023-24 through 2026-2027

Funding Categories	Estimated Amount
Personnel (3.25 FTEs in Yr. 1; 4 FTEs after) • Clinical Coordinator • Project Director Youth Coordinator/Peer Support Lead - youth outreach • Peer Support Specialist • Supported Education and Employment Specialist	1,177,050
Office/General Administrative includes the following: • Equipment maintenance • Staff Development/Training • Furniture maintenance and Rent • Building Improvement • Protective Health Information (PHI) / Electronic Health Records (EHR) maintenance	$1,099,000
Youth Materials and Advisory Expenses	$123,500
Indirect Management Overhead: • HR, Insurance, Accounting	$160,000
Misc / Unanticipated Changes (5%)	$127,978
Total:	**$2,687,528**

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Exhibit 1

Outcomes and Services

Process Outcomes:	Expected Due Date
1) Establish intake data collection	9/30/23
2) *allcove*™ South Orange County soft opening	10/1/23
3) Grand Opening	1/15/24
4) All WPC and UCI staff hired, per funding proposal	1/31/24
5) Have signed agreements with organizations to provide services not covered by WPC or UCI staff	6/30/24
6) Establish full operations of youth served across service streams	8/1/24
7) Conduct equity and inclusion survey (compare to OC population data for LGBTQ+ and race-ethnicity) among youth who engage in services, determine if youth served match the population of OC, and adjust services accordingly	8/1/24
Service Outcomes:	
1) Report the number of CalOptima Health members served compared to overall youth served	
2) 60% of Case Management referrals to resources, within *allcove*™ and the community continuum of care, will be completed each service year	
3) Net Promoter Score across all service streams of at least 70%	
4) 75% of youth report satisfaction with services and increased hopefulness after attending a session.	
5) 50% reduction in score by treatment end among 80% of *allcove*™ clients and a 70% reduction in mental health symptoms (includes somatic symptoms, depression, anxiety, substance misuse, and others) among 40% of *allcove*™ clients using the DSM 5 Cross Cutting Scale.	
6) The number of professional trainings, peer support specialist training, graduate student internships, predoctoral and postdoctoral positions in process or completed	

Required Reporting Elements

Reporting Requirements
1) Estimated number of CalOptima Health members served
2) Total number of CalOptima Health members served in this project
3) Actual number of CalOptima Health members served this reporting period
4) How much progress has been made towards your outcomes/objectives? If progress was not made, please explain.
5) What kind of unexpected successes or challenges have you encountered during this reporting period? If you encountered challenges, how did they mitigate?

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
22. Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund

Contacts
Michael Hunn, Chief Executive Officer (657) 900-1481
Yunkyung Kim, Chief Operating Officer (714) 923-8834

Recommended Actions
1. Create a restricted CalOptima Health Provider Workforce Development Fund in the amount of $50 million from existing reserves to support the education, training, recruitment, and retention of safety net providers in Orange County;
2. Direct the Chief Executive Officer to create a 5-year Provider Workforce Development Plan for the local safety net provider community; and
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background
The issue of health care provider shortages is one of the biggest challenges facing CalOptima Health and its community. In 2019, the California Future Health Workforce Commission projected that within 10 years, California would face a shortfall of more than 4,100 primary care clinicians and 600,000 home care workers, and would only have two-thirds of the psychiatrists it needs (Final Report of the California Future Health Workforce Commission, February 2019). Additionally, although California's population is becoming increasingly diverse, the health workforce does not reflect those demographics. These shortages and disparities are more pronounced in Medi-Cal, and projected workforce shortages have accelerated since the COVID-19 pandemic.

Discussion
CalOptima Health staff requests that the Board of Directors (Board) create a dedicated restricted reserve fund in the amount of $50 million to help address this looming crisis in the community. The funding will be used to create opportunities for education, training, recruitment, and retention of providers needed to serve CalOptima Health members.

Further, staff requests the Board to direct the Chief Executive Officer to develop a 5-year plan for local provider workforce development to include priority provider areas, funding strategies, and implementation plans for the Board's review and approval. CalOptima Health's plan will include learnings from existing statewide health workforce initiatives and engagement of local provider and member communities.

Fiscal Impact
An appropriation of up to $50 million from existing reserves will fund the restricted CalOptima Health Provider Workforce Development Fund.

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Rationale for Recommendation
The recommended action will support ongoing access to quality health providers for CalOptima Health's diverse membership.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
N/A

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

23. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Certain Health Networks to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

Contacts

Yunkyung Kim, Chief Operating Officer (714) 923-8834
Michael Gomez, Executive Director, Network Operations (714) 347-3262

Recommended Actions

1. Authorize the Chief Executive Officer to implement temporary, short-term supplemental Medi-Cal rate increases of up to 7.5% for certain Medi-Cal health networks for the period of July 1, 2023, through August 31, 2024;
2. Authorize the Chief Executive Officer to execute contract amendments and approve policies and procedures to implement these temporary, short-term public health emergency transition supplemental Medi-Cal rate increases; and
3. Authorize unbudgeted expenditures from existing reserves in an amount up to $34.0 million to support the public health emergency transition supplemental payment program.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency (PHE) under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. On January 30, 2023, the White House announced that the federal PHE would end on May 11, 2023. Furthermore, the fiscal year (FY) 2023 federal budget ended the continuous Medicaid coverage that had been in place during the PHE after March 31, 2023, triggering the commencement of Medi-Cal redetermination activities on April 1, 2023.

Throughout these past three years, CalOptima Health's Board of Directors (Board) took actions to protect the health and safety of providers and members and to ensure continued access to health care for members, including authorizing supplemental payments to providers for services related to COVID-19. On February 2, 2023, the Board authorized up to $6 million to support redetermination efforts for members and members' communities. The transition out of the PHE after three years and the member redetermination process will place additional strains on the provider delivery system.

Discussion

CalOptima Health staff requests that the Board approve the implementation of temporary, short-term supplemental rate increases to health networks and contracted providers except community clinics, to support the delivery systems' transition out of the PHE and the impacts of Medi-Cal redetermination.

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Staff propose to build upon the methodology the Board previously approved for COVID-19 supplemental payments.

Staff propose to designate the period of July 1, 2023, through August 31, 2024, as the transition period. This period is based on the first month of impact for Medi-Cal redetermination disenrollments. During this period, staff propose to provide a 7.5% increase from contracted Medi-Cal capitation base rates in effect each month on child, adult, and seniors and persons with disabilities (SPD) categories of aid to contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organization (HMO) health networks, except for Kaiser Foundation Health Plan.

Staff will monitor utilization and select quality metrics for access and quality care across the delivery system to monitor the impact of these funds during the transition period.

Fiscal Impact

The recommended actions will be funded by CalOptima Health reserves. An appropriation of up to $34.0 million in undesignated reserves will fund these actions for the fourteen (14)-month period of July 1, 2023, through August 31, 2024. The projected aggregate fiscal impact by provider type is as follows:

Provider Type	Estimated Amount (in millions)
Health Networks: Health Maintenance Organization	$13.3
Health Networks: Physician Hospital Consortia - Physician	$8.7
Health Networks: Physician Hospital Consortia - Hospital	$4.2
Health Networks: Shared Risk Group - Physician	$7.8
TOTAL	**$34.0**

Rationale for Recommendation

A temporary, short-term supplemental Medi-Cal payment program will support CalOptima Health's delivery system to ensure continuous access to care for members throughout the PHE transition period.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima Health Medi-Cal Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Care Medical Group	600 City Parkway West Ste. 800	Orange	CA	92868
CHOC Health Alliance	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Health Services	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
HPN Regal Medical Group	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Kaiser Permanente	393 E. Walnut St.	Pasadena	CA	91188
Noble Mid-Orange County	5785 Corporate Ave.	Cypress	CA	90630
Optum Care Network -Arta	3390 Harbor Blvd., Ste. 100	Costa Mesa	CA	92626
Optum Care - Monarch	1 Technology Dr.	Irvine	CA	92618
Optum Care -Talbert	3390 Harbor Blvd. Ste. 100	Costa Mesa	CA	92626
Prospect Medical Group	600 City Parkway West Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

24. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Hospitals Except Fountain Valley Regional Hospital & Medical Center, Los Alamitos Medical Center, and Placentia Linda Hospital, to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

Contacts

Yunkyung Kim, Chief Operating Officer (714) 923-8834
Michael Gomez, Executive Director, Network Operations (714) 347-3262

Recommended Actions

1. Authorize the Chief Executive Officer to implement temporary, short-term supplemental Medi-Cal rate increases of up to 7.5% for contracted fee-for-service hospitals except for Fountain Valley Regional Hospital & Medical Center, Los Alamitos Medical Center, and Placentia Linda Hospital, for the period of July 1, 2023, through August 31, 2024;
2. Authorize the Chief Executive Officer to execute contract amendments and approve policies and procedures to implement these temporary, short-term public health emergency transition supplemental Medi-Cal rate increases; and
3. Authorize unbudgeted expenditures from existing reserves in an amount up to $38.7 million to support the public health emergency transition supplemental payment program.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency (PHE) under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. On January 30, 2023, the White House announced that the federal PHE would end on May 11, 2023. Furthermore, the fiscal year (FY) 2023 federal budget ended the continuous Medicaid coverage that had been in place during the PHE after March 31, 2023, triggering the commencement of Medi-Cal redetermination activities on April 1, 2023.

Throughout these past three years, CalOptima Health's Board of Directors (Board) took actions to protect the health and safety of providers and members and to ensure continued access to health care for members, including authorizing supplemental payments to providers for services related to COVID-19. On February 2, 2023, the Board authorized up to $6 million to support redetermination efforts for members and members' communities. The transition out of the PHE after three years and the member redetermination process will place additional strains on the provider delivery system.

Discussion

CalOptima Health staff requests that the Board approve the implementation of temporary, short-term supplemental rate increases to fee-for-service hospitals to support the delivery systems' transition out of

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the PHE and the impacts of Medi-Cal redetermination. Staff propose to build upon the methodology the Board previously approved for COVID-19 supplemental payments.

Staff propose to designate the period of July 1, 2023, through August 31, 2024, as the transition period. This period is based on the first month of impact for Medi-Cal redetermination disenrollments. During this period, staff propose to provide a 7.5% increase from contracted rates in effect each month to hospitals contracted with CalOptima Health on a fee-for-service basis, for services provided to CalOptima Health Medi-Cal members enrolled in the CalOptima Health Community Network, CalOptima Direct, and Shared Risk Groups. Medically necessary covered services provided on dates of service July 1, 2023, through August 31, 2024, would qualify for the temporary rate increase.

The following services are excluded from the short-term supplemental Medi-Cal payment increase:

- Pharmacy and non-pharmacy administered drugs (carved-out under Medi-Cal Rx);
- Long-term care services;
- Durable medical equipment, orthotics, prosthetics and other medical devices;
- Crossover claims;
- Other supplemental or directed payments, such as Proposition 56;
- Cost of administrative services providers; and
- Claims paid by letter of agreement.

Staff will monitor utilization and select quality metrics for access and quality care across the delivery system to monitor the impact of these funds during the transition period.

Fiscal Impact

The recommended actions will be funded by CalOptima Health reserves and are approved through separate Board action. An appropriation of up to $38.7 million in undesignated reserves will fund these actions for the fourteen (14)-month period of July 1, 2023, through August 31, 2024.

Rationale for Recommendation

A temporary, short-term supplemental Medi-Cal payment program will support CalOptima Health's delivery system to ensure continuous access to care for members throughout the PHE transition period.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachment

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Hospitals				
Name	**Address**	**City**	**State**	**Zip Code**
Anaheim Global Medical Center	1025 S Anaheim Blvd	Anaheim	CA	92805
Anaheim Regional Medical Center	1111 W La Palma Ave	Anaheim	CA	92801
Beverly Hospital	309 W Beverly Blvd	Montebello	CA	90640
Cedars Sinai Medical Center	8700 Beverly Blvd	Los Angeles	CA	90048
Chapman Global Medical Center	2601 E Chapman Ave	Orange	CA	92869
Childrens Hospital of Los Angeles	4650 W Sunset Blvd	Los Angeles	CA	900276062
Children's Hospital of Orange County	1201 W La Veta Ave	Orange	CA	92868
CHOC Children's at Mission Hospital	27700 Medical Center Rd	Mission Viejo	CA	92691
City of Hope Medical Center	1500 E Duarte Rd	Duarte	CA	91010
College Hospital Costa Mesa	301 Victoria St	Costa Mesa	CA	92627
Foothill Regional Medical Center	14662 Newport Ave	Tustin	CA	927806064
Garden Grove Hospital Medical Center	12601 Garden Grove Blvd	Garden Grove	CA	928431908
Healthbridge Childrens Hospital	393 S Tustin St	Orange	CA	92866
Hoag Memorial Hospital Presbyterian	1 Hoag Dr	Newport Beach	CA	926634162
Hoag Memorial Hospital Presbyterian	16200 Sand Canyon Ave	Irvine	CA	92618
Huntington Beach Hospital	17772 Beach Blvd	Huntington Beach	CA	926476819
Kindred Hospital - Brea	875 N Brea Blvd	Brea	CA	92821
Kindred Hospital - La Mirada	14900 E Imperial Hwy	La Mirada	CA	90638
Kindred Hospital - Ontario	550 N Monterey Ave	Ontario	CA	91764
Kindred Hospital - Santa Ana	1901 N College Ave	Santa Ana	CA	92706
Kindred Hospital - Westminster	200 Hospital Circle	Westminster	CA	92683
Kindred Hospital-Los Angeles	5525 W Slauson Ave	Los Angeles	CA	90056
La Palma Intercommunity Hospital	7901 Walker St	La Palma	CA	906231722
Long Beach Memorial Medical Center	2801 Atlantic Ave	Long Beach	CA	90806
MemorialCare Miller Children's and Women's Hospital	2801 Atlantic Ave	Long Beach	CA	90806
MemorialCare Orange Coast Medical Center	9920 Talbert Ave	Fountain Valley	CA	92708
MemorialCare Saddleback Medical Center	24451 Health Center Dr	Laguna Hills	CA	92653
Orange County Global Medical Center	1001 N Tustin Ave	Santa Ana	CA	927053502
Pomona Valley Hospital Medical Center	1798 N Garey Ave	Pomona	CA	91767
Providence Mission Hospital	27700 Medical Center Rd	Mission Viejo	CA	92691
Providence Mission Hospital	31872 Coast Hwy	Laguna Beach	CA	92651
Providence St Joseph Hospital	1100 W Stewart Dr	Orange	CA	92868
Providence St Jude Medical Center	101 E Valencia Mesa Dr	Fullerton	CA	92835
South Coast Global Medical Center	2701 S Bristol St	Santa Ana	CA	927046201
UCI Medical Center	101 The City Dr South	Orange	CA	928683201
West Anaheim Medical Center	3033 W Orange Ave	Anaheim	CA	92804
Whittier Hospital Medical Center	9080 Colima Rd	Whittier	CA	90605

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

25. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Fee-for-Service Hospitals Fountain Valley Regional Hospital & Medical Center, Los Alamitos Medical Center, and Placentia Linda Hospital, to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

Contacts

Yunkyung Kim, Chief Operating Officer (714) 923-8834
Michael Gomez, Executive Director, Network Operations (714) 347-3262

Recommended Actions

1. Authorize the Chief Executive Officer to implement temporary, short-term supplemental Medi-Cal rate increases of up to 7.5% for fee-for-service hospitals Fountain Valley Regional Hospital & Medical Center, Los Alamitos Medical Center, and Placentia Linda Hospital, for the period of July 1, 2023, through August 31, 2024;
2. Authorize the Chief Executive Officer to execute contract amendments and approve policies and procedures to implement these temporary, short-term public health emergency transition supplemental Medi-Cal rate increases; and
3. Authorize unbudgeted expenditures from existing reserves in an amount up to $4.4 million to support the public health transition emergency supplemental payment program.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency (PHE) under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. On January 30, 2023, the White House announced that the federal PHE would end on May 11, 2023. Furthermore, the fiscal year (FY) 2023 federal budget ended the continuous Medicaid coverage that had been in place during the PHE after March 31, 2023, triggering the commencement of Medi-Cal redetermination activities on April 1, 2023.

Throughout these past three years, CalOptima Health's Board of Directors (Board) took actions to protect the health and safety of providers and members and to ensure continued access to health care for members, including authorizing supplemental payments to providers for services related to COVID-19. On February 2, 2023, the Board authorized up to $6 million to support redetermination efforts for members and members' communities. The transition out of the PHE after three years and the member redetermination process will place additional strains on the provider delivery system.

Discussion

CalOptima Health staff requests that the Board approve the implementation of temporary, short-term supplemental rate increases to fee-for-service hospitals to support the delivery systems' transition out of

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the PHE and the impacts of Medi-Cal redetermination. Staff propose to build upon the methodology the Board previously approved for COVID-19 supplemental payments.

Staff propose to designate the period of July 1, 2023, through August 31, 2024, as the transition period. This period is based on the first month of impact for Medi-Cal redetermination disenrollments. During this period, staff propose to provide a 7.5% increase from contracted rates in effect each month to hospitals contracted with CalOptima Health on a fee-for-service basis. The increase will apply to services provided to CalOptima Health Medi-Cal members enrolled in the CalOptima Health Community Network, CalOptima Direct, and Shared Risk Groups. Medically necessary covered services provided on dates of service July 1, 2023, through August 31, 2024, would qualify for the temporary rate increase.

The following services are excluded from the short-term supplemental Medi-Cal payment increase:

- Pharmacy and non-pharmacy administered drugs (carved-out under Medi-Cal Rx);
- Long-term care services;
- Durable medical equipment, orthotics, prosthetics and other medical devices;
- Crossover claims;
- Other supplemental or directed payments, such as Proposition 56;
- Cost of administrative services providers; and
- Claims paid by letter of agreement.

Staff will monitor utilization and select quality metrics for access and quality care across the delivery system to monitor the impact of these funds during the transition period.

Fiscal Impact

The recommended actions will be funded by CalOptima Health reserves. An appropriation of up to $4.4 million in undesignated reserves will fund these actions for the fourteen (14)-month period of July 1, 2023, through August 31, 2024.

Rationale for Recommendation

A temporary, short-term supplemental Medi-Cal payment program will support CalOptima Health's delivery system to ensure continuous access to care for members throughout the PHE transition period.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachment

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *05/26/2023*

Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Tenet Hospitals				
Name	**Address**	**City**	**State**	**Zip Code**
Fountain Valley Regional	17100 Euclid St.	Fountain Valley	CA	92708
Los Alamitos Medical Center	3751 Katella Ave.	Los Alamitos	CA	90720
Placentia-Linda Hospital	1301 N. Rose Dr.	Placentia	CA	92870

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

26. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Community Clinics AltaMed Health Services Corporation, to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

Contacts

Yunkyung Kim, Chief Operating Officer (714) 923-8834
Michael Gomez, Executive Director, Network Operations (714) 347-3262

Recommended Actions

1. Authorize the Chief Executive Officer to implement a temporary, short-term supplemental Medi-Cal rate increase of up to 7.5% for contracted Community Clinic AltaMed Health Services Corporation, for the period of July 1, 2023, through August 31, 2024;
2. Authorize the Chief Executive Officer to execute contract amendments and approve policies and procedures to implement this temporary, short-term public health emergency transition supplemental Medi-Cal rate increase; and
3. Authorize unbudgeted expenditures from existing reserves in an amount up to $0.16 million to support the public health transition emergency supplemental payment program.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency (PHE) under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. On January 30, 2023, the White House announced that the federal PHE would end on May 11, 2023. Furthermore, the fiscal year (FY) 2023 federal budget ended the continuous Medicaid coverage that had been in place during the PHE after March 31, 2023, triggering the commencement of Medi-Cal redetermination activities on April 1, 2023.

Throughout these past three years, CalOptima Health's Board of Directors (Board) took actions to protect the health and safety of providers and members and to ensure continued access to health care for members, including authorizing supplemental payments to providers for services related to COVID-19. On February 2, 2023, the Board authorized up to $6 million to support redetermination efforts for members and members' communities. The transition out of the PHE after three years and the member redetermination process will place additional strains on the provider delivery system.

Discussion

CalOptima Health staff requests that the Board approve the implementation of a temporary, short-term supplemental rate increase for contracted community clinics to support their transition out of the PHE and the impacts of Medi-Cal redetermination. Staff propose to build upon the methodology the Board previously approved for COVID-19 supplemental payments.

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Staff propose to designate the period of July 1, 2023, through August 31, 2024, as the transition period. This period is based on the first month of impact for Medi-Cal redetermination disenrollments.

Staff propose that Community Clinics receive a PHE transition supplemental payment in the form of a 7.5% increase from contracted rates in effect each month for services provided to CalOptima Health Medi-Cal members enrolled in the CalOptima Health Community Network and CalOptima Direct. Medically necessary covered services provided on dates of service July 1, 2023, through August 31, 2024, would qualify for the temporary rate increase.

The following services are excluded from the community clinics' short-term supplemental Medi-Cal payment increase:

- Pharmacy and non-pharmacy administered drugs;
- Long-term care services;
- Durable medical equipment, orthotics, prosthetics and other medical devices;
- Crossover claims;
- Other supplemental or directed payments, such as Proposition 56;
- Cost of administrative services providers; and
- Claims paid by letter of agreement.

Staff will monitor utilization and select quality metrics for access and quality care across the delivery system to monitor the impact of these funds during the transition period.

Fiscal Impact

The recommended actions will be funded by CalOptima Health reserves. An appropriation of up to $0.16 million in undesignated reserves will fund these actions for the fourteen (14)-month period of July 1, 2023, through August 31, 2024.

Rationale for Recommendation

A temporary, short-term supplemental Medi-Cal payment program will support CalOptima Health's delivery system to ensure continuous access to care for members throughout the PHE transition period.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Community Clinics – AltaMed Only				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services - East Los Angeles/Whittier	5427 Whittier Blvd	Los Angeles	CA	90022
AltaMed Health Services - Santa Ana Main	1400 N Main St	Santa Ana	CA	927012321
AltaMed Health Services-Orange	4010 E Chapman Ave	Orange	CA	92869
AltaMed Medical & Dental Group - Anaheim	1325 N Anaheim Blvd Suite 200	Anaheim	CA	928011202
AltaMed Medical Group-Garden Grove	12751 Harbor Blvd	Garden Grove	CA	928405800
AltaMed Medical Group-Santa Ana, Bristol	2720 S Bristol St Suite 100 110	Santa Ana	CA	927046207
AltaMed Medical and Dental Group-Huntington Beach	8041 Newman Ave	Huntington Beach	CA	92647

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

27. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Community Clinics, except AltaMed Health Services Corporation, to Support Expenses for Services Provided to Members During the Transition out of the Public Health Emergency

Contacts

Yunkyung Kim, Chief Operating Officer (714) 923-8834
Michael Gomez, Executive Director, Network Operations (714) 347-3262

Recommended Actions

1. Authorize the Chief Executive Officer to implement a temporary, short-term supplemental Medi-Cal rate increase of up to 7.5% for contracted Community Clinics, except AltaMed Health Services Corporation, for the period of July 1, 2023, through August 31, 2024;
2. Authorize the Chief Executive Officer to execute contract amendments and approve policies and procedures to implement this temporary, short-term public health emergency transition supplemental Medi-Cal rate increase; and
3. Authorize unbudgeted expenditures from existing reserves in an amount up to $0.95 million to support the public health emergency transition supplemental payment program.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency (PHE) under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. On January 30, 2023, the White House announced that the federal PHE would end on May 11, 2023. Furthermore, the fiscal year (FY) 2023 federal budget ended the continuous Medicaid coverage that had been in place during the PHE after March 31, 2023, triggering the commencement of Medi-Cal redetermination activities on April 1, 2023.

Throughout these past three years, CalOptima Health's Board of Directors (Board) took actions to protect the health and safety of providers and members and to ensure continued access to health care for members, including authorizing supplemental payments to providers for services related to COVID-19. On February 2, 2023, the Board authorized up to $6 million to support redetermination efforts for members and members' communities. The transition out of the PHE after three years and the member redetermination process will place additional strains on the provider delivery system.

Discussion

CalOptima Health staff requests that the Board approve the implementation of a temporary, short-term supplemental rate increase for contracted Community Clinics to support their transition out of the PHE and the impacts of Medi-Cal redetermination. Staff propose to build upon the methodology the Board previously approved for COVID-19 supplemental payments.

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Staff propose to designate the period of July 1, 2023, through August 31, 2024, as the transition period. This period is based on the first month of impact for Medi-Cal redetermination disenrollments.

Staff propose that Community Clinics receive a PHE transition supplemental payment in the form of a 7.5% increase from contracted rates in effect each month for services provided to CalOptima Health Medi-Cal members enrolled in the CalOptima Health Community Network and CalOptima Direct. Medically necessary covered services provided on dates of service July 1, 2023, through August 31, 2024, would qualify for the temporary rate increase.

The following services are excluded from the community clinics' short-term supplemental Medi-Cal payment increase:

- Pharmacy and non-pharmacy administered drugs;
- Long-term care services;
- Durable medical equipment, orthotics, prosthetics and other medical devices;
- Crossover claims;
- Other supplemental or directed payments, such as Proposition 56;
- Cost of administrative services providers; and
- Claims paid by letter of agreement.

Staff will monitor utilization and select quality metrics for access and quality care across the delivery system to monitor the impact of these funds during the transition period.

Fiscal Impact

The recommended actions will be funded by CalOptima Health reserves. An appropriation of up to $0.95 million in undesignated reserves will fund these actions for the fourteen (14)-month period of July 1, 2023, through August 31, 2024.

Rationale for Recommendation

A temporary, short-term supplemental Medi-Cal payment program will support CalOptima Health's delivery system to ensure continuous access to care for members throughout the PHE transition period.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Community Clinics – Except AltaMed				
Name	**Address**	**City**	**State**	**Zip Code**
APLA Health & Wellness	1043 Elm Ave Suite 302	Long Beach	CA	90813
Benevolence Health Center	3631 Crenshaw Blvd Suite 109	Los Angeles	CA	90016
Benevolence Health Center	805 W La Veta Ave Suite 110	Orange	CA	92868
Benevolence Health Center Anaheim	303 N East St	Anaheim	CA	928053341
CHOC Clinic at Garden Grove	10602 Chapman Ave Suite 100	Garden Grove	CA	928403147
CHOC Orange Clinic	1120 W La Veta Ave Suite 125	Orange	CA	928684235
CHOC Orange Clinic	3745 W Chapman Ave	Orange	CA	928681605
CHOC Outreach Clinics-Boys and Girls Club of Santa Ana	1000 Highland St	Santa Ana	CA	92703
Camino Health Center	1300 Avenida Vista Hermosa Suite 250	San Clemente	CA	926736340
Camino Health Center	30300 Camino Capistrano	San Juan Capistrano	CA	926751304
Camino Health Center	22481 Aspan St Suite A	Lake Forest	CA	926301630
Celebrating Life Community Health Center	27800 Medical Center Rd Suite 109 110	Mission Viejo	CA	926916407
Center for Inherited Blood Disorders	701 S Parker Suite 1000	Orange	CA	92868
Central City Community Health Center	12116 Beach Blvd	Stanton	CA	906803704
Central City Community Health Center	2237 W Ball Rd	Anaheim	CA	928045314
Central City Community Health Center	12116 Beach Blvd	Stanton	CA	906803704
Central City Community Health Center	12220 Foothill Blvd	Sylmar	CA	913426001
Central City Community Health Center	12511 Brookhurst St	Garden Grove	CA	928404806
Central City Community Health Center	12511 Brookhurst St 2nd Flr	Garden Grove	CA	928404806
Central City Community Health Center	201 W Wardlow Rd	Long Beach	CA	908074428
Central City Community Health Center	2237 W Ball Rd	Anaheim	CA	928045314
Central City Community Health Center	2335 Mountain Ave	Duarte	CA	91010
Central City Community Health Center	5970 S Central Ave	Los Angeles	CA	900011150
Clinica CHOC Para Ninos	406 S Main St	Santa Ana	CA	927015712
Community Medicine Inc	301 N Main St	Santa Ana	CA	927014852
Community Medicine Inc	8540 Alondra Blvd Suite B2	Paramount	CA	907235200
Community Outreach Medical Services	1200 N Tustin Ave Suite 130	Santa Ana	CA	92705
Community Outreach Medical Services	1701 E McFadden Blvd Suite D	Santa Ana	CA	92705
Families Together of Orange County	11180 Warner Ave Suite 353	Fountain Valley	CA	92708
Families Together of Orange County	661 W First St Suite G	Tustin	CA	92780
Families Together of Orange County	9918 Katella Ave Suite A-C	Anaheim	CA	92804
Family Planning Associates	1901 N Tustin Ave	Santa Ana	CA	92705
Family Planning Associates	2777 Long Beach Blvd Suite 200	Long Beach	CA	90806
Friends of Family Health Center La Habra	501 S Idaho St Suite 100 and 190 and 250	La Habra	CA	906316047
Friends of Family Health Center Tustin	13152 Newport Ave Suite B	Tustin	CA	927803469
Hurtt Family Health Clinic	14642 Newport Ave Suite 200	Tustin	CA	927806058
Hurtt Family Health Clinic - Anaheim	947 S Anaheim Blvd Suite 260	Anaheim	CA	928055591
Hurtt Family Health Clinic - Santa Ana	1100B N Tustin Ave Suite A B D & F	Santa Ana	CA	927053505
Hurtt Family Health Clinic - Tustin	1 Hope Dr	Tustin	CA	927820221
KCS Health Center	19742 MacArthur Blvd Suite 250	Irvine	CA	926122488
KCS Health Center	451 W Lincoln Ave Suite 100	Anaheim	CA	928052912
KCS Health Center	7212 Orangethorpe Ave Suite 9A	Buena Park	CA	906214668
Laguna Beach Community Clinic	362 3rd St	Laguna Beach	CA	926512307
Livingstone Community Health Clinic	111 W Bastanchury Rd Suite 1A	Fullerton	CA	92835
Livingstone Community Health Clinic	12362 Beach Blvd Suite 10	Stanton	CA	90680

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Nhan Hoa Comprehensive Health Care Clinic	7761 Garden Grove Blvd	Garden Grove	CA	928414200
North Orange County Reg Health Foundation	1182 N Euclid St	Anaheim	CA	928011900
Obria Medical Clinic of Southern California	2001 E 1st St Suite 209	Santa Ana	CA	927054020
Planned Parenthood Anaheim	303 W Lincoln Ave Suite 105	Anaheim	CA	92805
Planned Parenthood Costa Mesa	1520 Nutmeg Pl Suite 101	Costa Mesa	CA	92626
Planned Parenthood Mission Viejo	26137 La Paz Rd Suite 200	Mission Viejo	CA	92691
Planned Parenthood Orange	700 S Tustin St	Orange	CA	928663425
Planned Parenthood Santa Ana	1421 E 17th St	Santa Ana	CA	92705
Planned Parenthood Westminster	14372 Beach Blvd	Westminster	CA	92683
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
Share Our Selves Community Health Center	1550 Superior Ave	Costa Mesa	CA	926273653
Share Our Selves Community Health Center	27725 Santa Margarita Pkwy Suite 101	Mission Viejo	CA	926916706
Share Our Selves Community Health Center	307 Placentia Ave Suite 107	Newport Beach	CA	926633307
Sierra Health Center	501 S Brookhurst Rd	Fullerton	CA	92833
Southland Intergrated Services	9862 Chapman Ave	Garden Grove	CA	92841
St Jude Neighborhood Health Centers	3232 Topaz Lane	Fullerton	CA	92831
St Jude Neighborhood Health Centers	330 E Orangewood Ave	Anaheim	CA	92802
St Jude Neighborhood Health Centers	725 W La Veta Ave Suite 260	Orange	CA	928684439
St Jude Neighborhood Health Centers	731 S Highland Ave	Fullerton	CA	92832
UCI Family Health Center - Anaheim	2441 W La Palma Ave	Anaheim	CA	928012658
UCI Family Health Center - Santa Ana	800 N Main St	Santa Ana	CA	927013576
VCC The Gary Center	1000 Vale Terrace	Vista	CA	92084
VCC The Gary Center	134 Grapevine Rd	Vista	CA	920833514
VCC The Gary Center	201 S Harbor Blvd	La Habra	CA	906315340
VCC The Gary Center	4002 Vista Way	Oceanside	CA	92056
VCC The Gary Center	818 Pier View Way	Oceanside	CA	920547982

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Continued to a future meeting

CalOptima Health Board Action Agenda Referral

Action To Be Taken May 4, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

28. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Fee-for-Service Physicians to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

Contacts

Yunkyung Kim, Chief Operating Officer (714) 923-8834
Michael Gomez, Executive Director, Network Operations (714) 347-3262

Recommended Actions

1. Authorize the Chief Executive Officer to implement temporary, short-term supplemental Medi-Cal rate increases of up to 7.5% for contracted fee-for-service physicians for the period of July 1, 2023, through August 31, 2024;
2. Authorize the Chief Executive Officer to execute contract amendments and approve policies and procedures to implement these temporary, short-term public health emergency transition supplemental Medi-Cal rate increases; and
3. Authorize unbudgeted expenditures from existing reserves in an amount up to $10.2 million to support the public health emergency transition supplemental payment program.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency (PHE) under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. On January 30, 2023, the White House announced that the federal PHE would end on May 11, 2023. Furthermore, the fiscal year (FY) 2023 federal budget ended the continuous Medicaid coverage that had been in place during the PHE after March 31, 2023, triggering the commencement of Medi-Cal redetermination activities on April 1, 2023.

Throughout these past three years, CalOptima Health's Board of Directors (Board) took actions to protect the health and safety of providers and members and to ensure continued access to health care for members, including authorizing supplemental payments to providers for services related to COVID-19. On February 2, 2023, the Board authorized up to $6 million to support redetermination efforts for members and members' communities. The transition out of the PHE after three years and the member redetermination process will place additional strains on the provider delivery system.

Discussion

CalOptima Health staff requests that the Board approve the implementation of temporary, short-term supplemental rate increases to contracted fee-for-service physicians, to support the delivery systems' transition out of the PHE and the impacts of Medi-Cal redetermination. Staff propose to build upon the methodology the Board previously approved for COVID-19 supplemental payments.

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Staff propose to designate the period of July 1, 2023, through August 31, 2024, as the transition period. This period is based on the first month of impact for Medi-Cal redetermination disenrollments. During this period, staff propose to provide a 7.5% increase from contracted rates in effect each month to physicians contracted with CalOptima Health for services provided to CalOptima Health Medi-Cal members enrolled in the CalOptima Health Community Network and CalOptima Direct. Medically necessary covered services provided on dates of service July 1, 2023, through August 31, 2024, would qualify for the temporary rate increase.

The following services are excluded from the short-term supplemental Medi-Cal payment increase:

- Pharmacy and non-pharmacy administered drugs (carved-out under Medi-Cal Rx);
- Long-term care services;
- Durable medical equipment, orthotics, prosthetics and other medical devices;
- Crossover claims;
- Other supplemental or directed payments, such as Proposition 56;
- Cost of administrative services providers; and
- Claims paid by letter of agreement.

Staff will monitor utilization and select quality metrics for access and quality care across the delivery system to monitor the impact of these funds during the transition period.

Fiscal Impact
The recommended actions will be funded by CalOptima Health reserves. An appropriation of up to $10.2 million in undesignated reserves will fund these actions for the fourteen (14)-month period of July 1, 2023, through August 31, 2024.

Rationale for Recommendation
A temporary, short-term supplemental Medi-Cal payment program will support CalOptima Health's delivery system to ensure continuous access to care for members throughout the PHE transition period.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
N/A

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

29. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Behavioral Health Providers to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

Contacts

Yunkyung Kim, Chief Operating Officer (714) 923-8834
Michael Gomez, Executive Director, Network Operations (714) 347-3262

Recommended Actions

1. Authorize the Chief Executive Officer to implement temporary, short-term supplemental Medi-Cal rate increases of up to 7.5% for Contracted Behavioral Health Providers for the period of July 1, 2023, through August 31, 2024;
2. Authorize the Chief Executive Officer to execute contract amendments and approve policies and procedures to implement these temporary, short-term public health emergency transition supplemental Medi-Cal rate increases; and
3. Authorize unbudgeted expenditures from existing reserves in an amount up to $6.0 million to support the public health emergency transition supplemental payment program.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency (PHE) under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. On January 30, 2023, the White House announced that the federal PHE would end on May 11, 2023. Furthermore, the fiscal year (FY) 2023 federal budget ended the continuous Medicaid coverage that had been in place during the PHE after March 31, 2023, triggering the commencement of Medi-Cal redetermination activities on April 1, 2023.

Throughout these past three years, CalOptima Health's Board of Directors (Board) took actions to protect the health and safety of providers and members and to ensure continued access to health care for members, including authorizing supplemental payments to providers for services related to COVID-19. On February 2, 2023, the Board authorized up to $6 million to support redetermination efforts for members and members' communities. The transition out of the PHE after three years and the member redetermination process will place additional strains on the provider delivery system.

Discussion

CalOptima Health staff requests that the Board approve the implementation of temporary, short-term supplemental rate increases to contracted Behavioral Health Providers, to support the delivery systems' transition out of the PHE and the impacts of Medi-Cal redetermination. Staff propose to build upon the methodology the Board previously approved for COVID-19 supplemental payments.

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Staff propose to designate the period of July 1, 2023, through August 31, 2024, as the transition period. This period is based on the first month of impact for Medi-Cal redetermination disenrollments. During this period, staff propose to provide a 7.5% increase from contracted rates in effect each month to Behavioral Health Providers contracted with CalOptima Health for services provided to all CalOptima Health Medi-Cal members. Medically necessary covered services provided on dates of service July 1, 2023, through August 31, 2024, would qualify for the temporary rate increase.

The following services are excluded from the short-term supplemental Medi-Cal payment increase:

- Pharmacy and non-pharmacy administered drugs (carved-out under Medi-Cal Rx);
- Long-term care services;
- Durable medical equipment, orthotics, prosthetics and other medical devices;
- Crossover claims;
- Other supplemental or directed payments, such as Proposition 56;
- Cost of administrative services providers; and
- Claims paid by letter of agreement.

Staff will monitor utilization and select quality metrics for access and quality care across the delivery system to monitor the impact of these funds during the transition period.

Fiscal Impact

The recommended actions will be funded by CalOptima Health reserves. An appropriation of up to $6.0 million in undesignated reserves will fund these actions for the fourteen (14)-month period of July 1, 2023, through August 31, 2024.

Rationale for Recommendation

A temporary, short-term supplemental Medi-Cal payment program will support CalOptima Health's delivery system to ensure continuous access to care for members throughout the PHE transition period.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

N/A

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

30. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Ancillary Providers to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

Contacts

Yunkyung Kim, Chief Operating Officer (714) 923-8834
Michael Gomez, Executive Director, Network Operations (714) 347-3262

Recommended Actions

1. Authorize the Chief Executive Officer to implement temporary, short-term supplemental Medi-Cal rate increases of up to 7.5% for contracted Ancillary Providers for the period of July 1, 2023, through August 31, 2024;
2. Authorize the Chief Executive Officer to execute contract amendments and approve policies and procedures to implement these temporary, short-term public health emergency transition supplemental Medi-Cal rate increases; and
3. Authorize unbudgeted expenditures from existing reserves in an amount up to $13.1 million to support the public health emergency transition supplemental payment program.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency (PHE) under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. On January 30, 2023, the White House announced that the federal PHE would end on May 11, 2023. Furthermore, the fiscal year (FY) 2023 federal budget ended the continuous Medicaid coverage that had been in place during the PHE after March 31, 2023, triggering the commencement of Medi-Cal redetermination activities on April 1, 2023.

Throughout these past three years, CalOptima Health's Board of Directors (Board) took actions to protect the health and safety of providers and members and to ensure continued access to health care for members, including authorizing supplemental payments to providers for services related to COVID-19. On February 2, 2023, the Board authorized up to $6 million to support redetermination efforts for members and members' communities. The transition out of the PHE after three years and the member redetermination process will place additional strains on the provider delivery system.

Discussion

CalOptima Health staff requests that the Board approve the implementation of temporary, short-term supplemental rate increases to contracted ancillary providers to support the delivery systems' transition out of the PHE and the impacts of Medi-Cal redetermination. Staff propose to build upon the methodology the Board previously approved for COVID-19 supplemental payments.

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Staff propose to designate the period of July 1, 2023, through August 31, 2024, as the transition period. This period is based on the first month of impact for Medi-Cal redetermination disenrollments. During this period, staff propose to provide a 7.5% increase from contracted rates in effect each month to ancillary providers contracted with CalOptima Health for services provided to CalOptima Health Medi-Cal members enrolled in the CalOptima Health Community Network and CalOptima Direct. Medically necessary covered services provided on dates of service July 1, 2023, through August 31, 2024, would qualify for the temporary rate increase.

The following services are excluded from the short-term supplemental Medi-Cal payment increase:

- Pharmacy and non-pharmacy administered drugs (carved-out under Medi-Cal Rx);
- Long-term care services;
- Durable medical equipment, orthotics, prosthetics and other medical devices;
- Crossover claims;
- Other supplemental or directed payments, such as Proposition 56;
- Cost of administrative services providers; and
- Claims paid by letter of agreement.

Staff will monitor utilization and select quality metrics for access and quality care across the delivery system to monitor the impact of these funds during the transition period.

Fiscal Impact

The recommended actions will be funded by CalOptima Health reserves. An appropriation of up to $13.1 million in undesignated reserves will fund these actions for the fourteen (14)-month period of July 1, 2023, through August 31, 2024.

Rationale for Recommendation

A temporary, short-term supplemental Medi-Cal payment program will support CalOptima Health's delivery system to ensure continuous access to care for members throughout the PHE transition period.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

31. Authorize Amendments to the CalOptima Health Medi-Cal Health Network Contracts, Effective July 1, 2023.

Contacts

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

Recommended Actions

1. Authorize amendments to the CalOptima Health Medi-Cal Health Network Contracts, except Kaiser Foundation Health Plan, effective July 1, 2023, to reflect:
    a. Capitation base rate changes including changes to Whole Child Model, maternity supplemental kick, and reinsurance provisions, as recommended by the recent Milliman rebasing analysis;
    b. Updated rates for Enhanced Care Management services; and
2. Authorize amendments to all CalOptima Health Medi-Cal Health Network Contracts to modify contract terms to align with program changes, including removal of provisions for funding for Health Homes Program and Whole Child Model Program start-up.

Background and Discussion

Staff requests the CalOptima Health Board of Directors (Board) authorize amendments to the CalOptima Health Medi-Cal Health Network contracts to update capitation base rates to align with the Milliman rebasing analysis. In aggregate, provider funding is increased by 0.5% for professional services and 5.5% for hospital services (2.9% combined), including changes to maternity supplemental kick and reinsurance provisions. The result of the Milliman rebasing analysis supports the rate adjustments. Kaiser Foundation Health Plan (Kaiser) is excluded from these amendments.

Staff also recommend an increase to Health Networks' rates for Enhanced Care Management (ECM) services by 8.5% from current rates to ensure that CalOptima Health sufficiently funds Health Networks and maintains a strong ECM provider network. Kaiser is excluded from these amendments.

In addition, staff requests authorization to modify contract terms for all health networks to align with program changes, including the following:

- Delete clause supporting funding for the Health Homes Program.
- Delete clause supporting funding for start-up expenses for the Whole Child Model Program.
- Replace all references to "Home Health Program" with "CalAIM Program," where applicable
- Delete references to "Personal Care Coordination (PCC) supplemental capitation payments," as it is no longer applicable.
- Add new sections detailing parameters for the PCC program.
- Add new language clarifying CalOptima Health's reporting obligations to providers regarding changes to member profiles.

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- Add new language reflecting the provision of ECM program services by Community Supports providers.
- Delete and replace language related to ECM.

Fiscal Impact
Management has included medical expenses associated with the capitation rate adjustments in the proposed CalOptima Health Fiscal Year 2023-24 Operating Budget. There is no additional fiscal impact for the recommended contract changes.

Rationale for Recommendation
Authorization of the above amendments will align CalOptima Health's Medi-Cal health network contract with current Department of Health Care Services updates and program requirements, as well as reflect current updated capitation rates for health network providers.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Board Action
2. Amendment to the CalOptima Health Contract for Health Care Services

Board Actions
N/A

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima Health Medi-Cal Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Care Medical Group	600 City Parkway West Ste. 800	Orange	CA	92868
CHOC Health Alliance	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Health Services	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
HPN Regal Medical Group	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Kaiser Permanente	393 E. Walnut St.	Pasadena	CA	91188
Noble Mid-Orange County	5785 Corporate Ave.	Cypress	CA	90630
Optum Care Network -Arta	3390 Harbor Blvd., Ste. 100	Costa Mesa	CA	92626
Optum Care - Monarch	1 Technology Dr.	Irvine	CA	92618
Optum Care -Talbert	3390 Harbor Blvd. Ste. 100	Costa Mesa	CA	92626
Prospect Medical Group	600 City Parkway West Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

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AMENDMENT __ TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT ___TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of **July 1, 2023** ("Amendment Effective Date"), by and between Orange County Health Authority, a Public Agency, dba CalOptima Health ("CalOptima"), and, _____ ("HMO/Physician/Hospital"), with respect to the following facts:

RECITALS

A. CalOptima and ("HMO/Physician/Hospital") have entered into a Contract for Health Care Services, originally effective **[insert date]**, ("Contract"), by which ("HMO/Physician/Hospital") has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and ("HMO/Physician/Hospital") desire to amend the Contract to administer updated capitation payments in accordance with June 1st 2023, Board Approved recommendations and CalOptima policy, and to reflect DHCS changes to Enhanced Care Management ("ECM") services.

C. CalOptima and ("HMO/Physician/Hospital") desire to amend the Contract to extend the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors through August 31, 2024 to assist provider in transition out of the public health emergency.

NOW, THEREFORE, the parties agree as follows:

1. Replace all references to "Basic Care Management" in the Contract with "Basic PHM."

2. Section 1.24, Complex Case Management, shall be deleted in its entirety and replaced with the following new Section 1.24, Complex Case Management:

   "1.24 "Complex Case Management" means an approach to case management that meets differing needs of high and rising-risk Members, including both ongoing chronic care coordination for chronic conditions and interventions for episodic, temporary needs. Complex Case Management includes all services and requirements under Basic PHM."

3. Sections 1.101, Community-Based Care Management Entity (CB-CME), 1.102, Health Homes Program or "HHP", 1.103, HHP Member and, 1.104, HHP Multi-Disciplinary Care Team shall be deleted in their entirety and replaced with "Intentionally left blank."

4. Section 1.106, Basic Case Management, shall be deleted in its entirety and replaced with the following new Section 1.106. Basic Population Health Management:

   "1.106 "Basic Population Health Management" or "Basic PHM" means CalOptima's approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's risk tier, at the right time and in the right setting. Basic PHM includes federal requirements for care coordination and comply with all applicable federal and state requirements, and National Committee for Quality Assurance ("NCQA") standards."

5. Section 6.15.14.1, Care Management Monthly Profile (Profile) shall be deleted in its entirety and replaced with the following new Section 6.15.14.1, Care Management Monthly Profile (Profile):

"6.15.14.1 "Care Management Monthly Profile (Profile)" is a monthly report generated by CalOptima which provides the healthcare risk outcomes for CCS and SPD Members."

6. Sections 6.15.14.4 and 6.15.14.5 shall be added to Section 6.15.14 as follows:

"6.15.14.4 ("HMO/Physician/Hospital") shall employ PCCs, and participate in all PCC Program requirements as defined in CalOptima Policy and the Profile. ("HMO/Physician/Hospital") shall staff one PCC per six hundred (600) CCS or SPD Members assigned to ("HMO/Physician/Hospital"). PCC responsibilities include but are not limited to: Assisting Members and Member's PCPs in the development of an Individual Care Plan (ICP); communicating the ICP with the Member, Member's PCP and Member's care team; and assisting Members receiving care as outlined in the ICP. ("HMO/Physician/Hospital") shall submit required reports and documents to CalOptima. These include but are not limited to ICPs, PCC staffing levels, and PCC and professional staff descriptions to demonstrate adherence to CalOptima Policy requirements.

6.15.14.5 CalOptima shall provide ("HMO/Physician/Hospital") with Profile requirements. Changes to the Profile, will be communicated to ("HMO/Physician/Hospital") thirty (30) days prior to the effective date of such change. If ("HMO/Physician/Hospital") is unable to agree to the requirements stipulated in the Profile, and no resolution is reached in the thirty (30) day period, further action may be taken including but not limited to recoupment of PCC supplemental funds that have been paid to ("HMO/Physician/Hospital") and termination of the Contract."

7. Sections 6.15.15 and 6.15.16 shall be deleted in their entirety.

8. Section 6.22, "HEALTH HOMES PROGRAM" shall be deleted in its entirety and replaced with "Intentionally left blank".

9. Section 6.23.1, ("HMO/Physician") Participation in CalOptima ECM, shall be deleted in its entirety and replaced with the following new Section 6.23.1, ("HMO/Physician") Participation in CalOptima ECM:

"6.23.1 ("HMO/Physician") Participation in CalOptima ECM – ("HMO/Physician") shall begin participating as an ECM Provider in CalOptima Enhanced Care Management, as set forth below, for CalOptima Members who meet the DHCS-defined criteria for one of the following Populations of Focus ("ECM Populations of Focus"):

6.23.1.1 For CalOptima adult Members who meet the DHCS-defined criteria for one of the following: (i) Individuals Experiencing Homelessness; (ii) "Individuals At Risk for Avoidable Hospital or ED Utilization (formerly

known as "High utilizer"); (iii) Individuals with Serious Mental Illness ("SMI") and/or Substance Use Disorder ("SUD") Needs; (iv) Individuals Transitioning from Incarceration; (v) Individuals with Intellectual or Developmental Disabilities ("I/DD"); or (vi) Pregnancy, Postpartum, and Birth Equity Population of Focus.

6.23.1.2 Effective January 1, 2023, or such later date as determined by DHCS, for CalOptima Members who meet the DHCS-defined criteria for one of the following: (i) Adults Living in the Community and At Risk for Long Term Care (LTC) Institutionalization; or (ii) Adult Nursing Facility Residents Transitioning to the Community.

6.23.1.3 Effective July 1, 2023, or such later date as determined by DHCS, for other CalOptima children and youth who meet the DHCS-defined criteria for one of the following: (i) Individuals Experiencing Homelessness; (ii) "Individuals At Risk for Avoidable Hospital or ED Utilization (formerly known as "High utilizer"); (iii) Individuals with SMI and/or SUD Needs; (iv) Individuals Transitioning from Incarceration; (v) Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition; (vi) Children and Youth Involved in Child Welfare (including foster care up to age 26); (vii) I/DD; or (viii) Pregnancy, Postpartum, and Birth Equity Population of Focus.

6.23.1.4 Effective January 1, 2024, or such later date as determined by DHCS, for Members who meet the DHCS-defined criteria for one of the following: (i) Pregnancy, Postpartum, and Birth Equity Population of Focus (who are subject to racial and ethnic disparities)."

10. Section 6.23.8, Initiating Delivery of ECM, shall be deleted in its entirety and replaced with the following new Section 6.23.8, Initiating Delivery of ECM:

"6.23.8 Initiating Delivery of ECM – ECM Provider shall obtain, document, and manage Member authorization for the sharing of personally identifiable information between CalOptima and ECM, Community Supports, and other Providers involved in the provision of Member care to the extent required by federal law.

6.23.8.1 Member authorization for ECM-related data sharing is not required for the ECM Provider to initiate delivery of ECM unless such authorization is required by federal law. When federal law requires authorization for data sharing, ECM Provider shall communicate that it has obtained Member authorization for such data sharing back to CalOptima.

6.23.8.2 ECM Provider shall notify CalOptima to discontinue ECM under the following circumstances: (i) The Member has met their care plan goals for ECM; (ii) The Member is ready to transition to a lower level of care; (iii) The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or (iv) ECM Provider has not had any contact with the Member after three (3) attempts.

6.23.8.3 When ECM is discontinued, or will be discontinued for the Member, Provider is responsible for sending a notice of action notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is informed of their right to appeal and the appeals process as instructed in the notice of action. ECM Provider shall communicate to the Member other

benefits or programs that may be available to the Member, as applicable (e.g., Complex Case Management, Basic PHM, etc.)."

11. Section 9.1.3, Capitation Payment Withhold shall be deleted in its entirety and replaced with the following new Section 9.1.3, Capitation Payment Withhold:

"9.1.3 Capitation Payment Withhold - CalOptima shall withhold from ("HMO/Physician/Hospital") an amount equal to twenty-five percent (25%) of one (1) months Capitation Payment (Withhold). CalOptima may adjust ("HMO/Physician/Hospital")'s Capitation Payment in accordance with Policy FF.3002."

12. Attachment E – Amendment #, "Capitation Rates", shall be deleted in its entirety and replaced with the attached Attachment E – Amendment # "Capitation Rates".

13. Attachment E-1 – Amendment #, "Capitation Rates for Adult Expansion Members" shall be deleted in its entirety.

14. Attachment E-5 – Amendment VI, "Funding for Health Homes Program (HHP)" shall be deleted in its entirety and replaced with "Intentionally left blank".

15. Attachment E-6, "Whole-Child Model (WCM) Program Start-up Expense Reimbursement" shall be deleted in its entirety and replaced with "Intentionally left blank".

16. Attachment E-# - Amendment #, "MEDI-CAL RATE ENHANCEMENT" shall be deleted in its entirety and replaced with the attached Attachment E-# - Amendment # "MEDI-CAL RATE ENHANCEMENT".

17. Attachment E-10, "Funding for Enhanced Care Management (ECM) Services", shall be deleted in its entirety and replaced with the attached Attachment E-10 – Amendment #, "Funding for Enhanced Care Management (ECM) Services".

CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue 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. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS THEREOF, CalOptima and {Insert HN Name Here} have executed this Amendment:

FOR ("HMO/Physician/Hospital"):	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim_____
PRINT NAME	PRINT NAME
_____	Chief Operating Officer_____
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT E - AMENDMENT #
Capitation Rates

Effective July 1, 2023

Payments by CalOptima to Health Network for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Child/Adult	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40-64 years, Both			
	65+ years, Both			
Medi-Cal Expansion	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female		ALL RATES REDACTED	
	19-39 years, Male			
	40- 64 years, Both			
	65+ years, Both			
SPD	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40- 64 years, Both			
	65+ years, Both			
WCM	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-21 years, Female			
	19-21 years, Male			

Aid Code	Age & Gender	Base	Base	Total

				Cap
Category	**Category**	**Hospital**	**Physician**	**Rate**
ESRD	All ages, Both			
AIDS	All ages, 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 policy.

Supplemental OB Delivery Care Payment will be payable for all qualified deliveries based on DHCS guidance.

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment - All			

ATTACHMENT E-# - AMENDMENT

MEDI-CAL RATE ENHANCEMENT

For the period from July 1, 2023, through August 31, 2024, the (HMO/Physician/Hospital) rates set forth in Attachment E - Amendment # for the Child/Adult and SPD aid code categories shall be increased by ___%. This rate enhancement shall not apply to the capitation rates for ESRD and AIDS aid code categories, the Whole Child Model and Medi-Cal Expansion base capitation rates in Attachment E - Amendment #, or the Funding for Enhanced Care Management (ECM) Services in Attachment E-10 – Amendment #. Following August 31, 2024, the ___% increase shall cease, and the rates under the Contract shall revert to pre- COVID-19 PHE levels unless the Contract is further amended by the parties.

ATTACHMENT E-# – AMENDMENT #

Funding for Enhanced Care Management (ECM) Services

Effective July 1, 2023, subject to approval by DHCS, CalOptima shall make an ECM Supplemental Payment to ("HMO/Physician") for ECM services provided to an ECM Member, in accordance with the terms and conditions of CalOptima Policy FF.4002.

1. ECM Services Supplemental Payment

   1.1 CalOptima shall pay ("HMO/Physician") the ECM Supplemental Payment rate of $[redacted] PMPM for each Member who receives two (2) or more hours of ECM services in a given month as identified by eight (8) or more units, subject to ("HMO/Physician")'s compliance with all of the following conditions:

   - Member is identified as an ECM-eligible Member as determined by CalOptima based on ECM eligibility criteria as defined by DHCS and in accordance with CalOptima Policy GG.1354;
   - Member is authorized to receive ECM services;
   - Member receives one of the ECM core service components (as set forth in Section 6.23.9.4 of the Contract) in the prior month;
   - The ECM services are billed and reported to CalOptima consistent with CalOptima Policy FF.4002 and DHCS requirements; and;
   - If applicable, the ("HMO/Physician") paid the provider for the ECM services; and
   - The ("HMO/Physician") authorized such ECM services.

   1.2 For purposes of this Attachment E-10 only, the term "PMPM" means an all-inclusive case rate that applies whenever ("HMO/Physician"), as the ECM Provider, has provided the minimum level of service payable to an enrolled Member. This rate is paid on the basis of submitted claims and is not to be considered a capitation payment.

2. ("HMO/Physician") shall submit ECM billing data for the ECM Services Supplemental Payment in accordance with CalOptima Policy FF.4002.

3. Upon validation of the ECM billing data and in accordance with CalOptima Policy FF.4002 CalOptima shall pay ninety (90) percent of all clean claims within thirty (30) calendar days of the date of receipt and ninety-nine (99) percent of all clean claims within ninety (90) calendar days of the date of receipt. The date of receipt shall be the date CalOptima receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

4. In addition to Section 9.4 of this Contract, ("HMO/Physician") agrees to CalOptima's recovery of any overpayment of ECM Services Supplemental Payment in accordance with CalOptima Policy FF.4002.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

32. Authorize Amendments to the CalOptima Health Ancillary Contracts with Community Supports Providers to Incorporate Enhanced Care Management Program Services in Accordance with Department of Health Care Services Requirements, Effective July 1, 2023

Contacts

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

Recommended Actions

Authorize staff to amend the CalOptima Health Ancillary Services Contracts with Community Supports providers as follows:

1. Incorporate Enhanced Care Management (ECM) program services and modifications that align with updates in the Department of Health Care Services (DHCS) ECM Policy Guide, effective July 1, 2023; and
2. Implement new ECM provider case rates.

Background and Discussion

Staff requests authorization to amend CalOptima Health's Ancillary Services Contracts with Community Supports providers to reflect ECM program services and modifications based on the updated DHCS ECM Policy Guide, as well as reflect an increase to ECM provider case rates. Pending CalOptima Health Board of Directors' approval, the amendments will be effective July 1, 2023.

In accordance with the DHCS ECM Policy Guide, the proposed amendments to CalOptima Health's Ancillary Services Contracts with Community Supports providers will reflect the following changes effective July 1, 2023:

- New ECM program services.
- Expanded eligibility criteria to persons regardless of risk level.
- Expanded ECM program services to the following persons:
    - Children and youth with intellectual or developmental disabilities, behavioral health disorders, and/or receiving child welfare services through the California Department of Social Services (CDSS);
    - Individuals transitioning out of incarceration; and
    - Pregnant and postpartum individuals.
- Replaced references to "Basic Care Management" with "Basic PHM" (Population Health Management).
- Addition of new language clarifying CalOptima Health's reporting obligations to providers regarding changes to member profiles.
- Addition of new language reflecting the provision of ECM program services by Community Supports providers.
- Updated requirements for member outreach prior to discontinuation of ECM program services.

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Staff recommends an 8.5% increase to the current ECM provider case rates. The increase in provider case rates reflects DHCS's most current program assumptions on resource intensity and administrative costs associated with providing this benefit.

Staff requests authorization from the CalOptima Health Board of Directors to amend CalOptima Health's Ancillary Services Contracts with Community Supports providers to ensure ECM program services are administered in alignment with DHCS most current program requirements.

Fiscal Impact
Management has included $1.94 million for total ECM fee-for-service claims expense in the proposed CalOptima Health Fiscal Year 2023-24 Operating Budget. The proposed budget accounts for the recommended increase of 8.5% or $165,000 to the ECM provider case rate. There is no additional fiscal impact for the recommended contract language changes.

Rationale for Recommendation
Authorization of the above amendments will align CalOptima Health's Ancillary Services Contracts with Community Supports providers for the provision of ECM program services with current DHCS updates, recommendations, and program requirements.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Board Action
2. Amendment to the CalOptima Health Ancillary Services Contract with Community Supports providers.

Board Actions
N/A

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Abrazar, Inc.	7101 Wyoming Street	Westminster	CA	92683
AIDS Services Foundation Orange County dba Radiant Health Centers	17982 Sky Park Circle	Irvine	CA	92614
American Family Housing	15161 Jackson Street,	Midway City	CA	92655
Angelian Management Group LLC dba Laguna Adult Day Health Center	23551 Moulton Parkway	Laguna Hills	CA	92653
Camino Health Center	1031 Avenida Pico	San Clemente	CA	92673
Celebrating Life Community Health Center	27800 Medical Center Road	Mission Viejo	CA	92691
Clarke Lew Medical Corp. dba Illumination Foundation Medical Group	3535 W Commonwealth Avenue	Fullerton	CA	92833
Families Together of Orange County	661 W. 1st Street	Tustin	CA	92780
Healthcare in Action Medical Group	3800 Kilroy Airport Way, Suite 100	Long Beach	CA	90806
Housing For Health Orange County, Inc.	17701 Cowan	Irvine	CA	92614
Hurtt Family Health Clinic, Inc.	1 Hope Dr	Tustin	CA	927820221
JSI Acquisitions, Inc dba Libertana Home Health	5805 Sepulveda Blvd, Suite 605	Sherman Oaks	CA	91411
Korean Community Services Inc. dba KCS Health Center	7212 Orangethhorpe Avenue	Buena Park	CA	90621
North Orange County Regional Health Foundation	901 W. Orangethorpe Avenue	Fullerton	CA	92832
PATH	340 N. Madison Avenue	Los Angeles	CA	90004
Seneca Family of Agencies	8945 Golf Links Road	Oakland	CA	94605
Share Our Selves Corporation	1014 N Broadway	Santa Ana	CA	92701
Southland Integrated Services, Inc.	9862 Chapman Ave	Garden Grove	CA	92841
St. Jude Neighborhood Health Centers	3232 Topaz Lane	Fullerton	CA	92831
Sterling Hospitalist Medical Group, Inc. dba Titanium Healthcare	12566 Valley View Street	Garden Grove	CA	92845
Vista Community Clinic dba VCC: The Gary Center	1000 Vale Terrace	Vista	CA	92084
Volunteers of America of Los Angeles	3600 Wilshire Blvd, Suite 1500	Los Angeles	CA	90010

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AMENDMENT @@AMENDMENT NUMBER@@ TO

ANCILLARY SERVICES CONTRACT

This Amendment @@Amendment Number@@ to the Ancillary Services Contract ("Amendment") is effective as of **@@Amendment Effective Date@@** ("Amendment Effective Date") by and between the Orange County Health Authority, a public agency, dba CalOptima Health ("CalOptima"), and [Test Provider - CalOptima Use Only] ("Provider"). CalOptima and Provider may each be referred to herein as a "Party" and collectively as the "Parties".

RECITALS

A. CalOptima and Provider have entered into an Ancillary Services Contract ("Contract"), originally effective @@Actual Effective Date@@, by which Provider agrees to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Provider desire to amend the Contract to specify requirements, responsibilities, and reimbursement rates related to CalOptima's Enhanced Care Management ("ECM") services for DHCS's California Advancing and Innovating Medi-Cal ("CalAIM") initiative.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Section 1.20, ECM Provider, of the Contract shall be deleted in its entirety and replaced with the following new Section 1.20:

   1.20 "ECM Provider" means Provider when providing ECM services to ECM Members pursuant to this Contract.

2. Section 1.41, Basic Care Management, shall be deleted and replaced with the following new Section 1.41, "Basic Population Health Management":

   1.41 "Basic Population Health Management" or "Basic PHM" means CalOptima's approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's risk tier, at the right time and in the right setting. Basic PHM includes federal requirements for care coordination and comply with all applicable federal and state requirements, and National Committee for Quality Assurance ("NCQA") standards.

3. Section 1.42, Complex Case Management, shall be deleted and replaced with the following new Section 1.42, Complex Case Management, to the Contract:

   1.42 "Complex Case Management" means an approach to care management that meets differing needs of high and rising-risk Members, including both ongoing chronic care coordination for chronic conditions and interventions for episodic, temporary needs. Complex Case Management includes all services and requirements under Basic PHM.

4. Section 1.43, ECM Care Term, shall be added to the Contract:

   1.43 "ECM Care Team" means a team of staff employed or contracted by the Provider, as an ECM Provider, that provides ECM services to ECM Members.

5. Section 1.44, ECM Member, shall be added to the Contract:

   1.44 "ECM Member" means a CalOptima Medi-Cal Member who meets inclusion criteria for one of the ECM Populations of Focus, authorized by CalOptima to receive ECM services.

6. Section 1.45, Lead Care Manager, shall be added to the Contract:

1.45 "Lead Care Manager" means a Member's designated care manager for ECM who works for the ECM Provider's organization. The Lead Care Manager operates as part of the Member's ECM Care Team and is responsible for coordinating all aspects of ECM and any Community Supports. To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.

7. Section 2.43, Enhanced Care Management, shall be added to the Contract:

2.43 Enhanced Care Management.

2.43.1 Provider Participation in CalOptima ECM. Provider shall begin participating as an ECM Provider, as set forth in this section, for Members who meet the DHCS-defined criteria for one of the following populations of focus ("ECM Populations of Focus") as authorized by and assigned to ECM provider by CalOptima:

2.43.1.1 For CalOptima adult Members who meet the DHCS-defined criteria for one of the following ECM Populations of Focus:

(i) Individuals experiencing homelessness;

(ii) Individuals at risk for avoidable hospital or ED Utilization (formerly known as "high utilizer");

(iii) Individuals with serious mental illness ("SMI") and/or substance use disorder ("SUD") needs;

(iv) Individuals transitioning from incarceration;

(v) Individuals with intellectual or developmental disabilities ("I/DD"); or

(vi) Pregnancy, postpartum, and birth equity population of focus.

2.43.1.2 Effective January 1, 2023, or such later date as determined by DHCS, for Members who meet the DHCS-defined criteria for one of the following:

(i) Adults living in the community and at risk for long term care ("LTC") institutionalization; or

(ii) Adult nursing facility residents transitioning to the community.

2.43.1.3 Effective July 1, 2023, or such later date as determined by DHCS, for other children and youth Members who meet the DHCS-defined criteria for one of the following:

(i) Individuals experiencing homelessness;

(ii) Individuals at risk for avoidable hospital or ED Utilization (formerly known as "high utilizer");

(iii) Individuals with SMI and/or SUD needs;

(iv) Individuals transitioning from incarceration;

(v) Children and youth enrolled in CCS or CCS WCM with additional needs beyond the CCS condition;

(vi) Children and youth involved in child welfare (including foster care up to age 26);

(vii) I/DD; or

(viii) Pregnancy, postpartum, and birth equity population of focus.

2.43.1.4 Effective January 1, 2024, or such later date as determined by DHCS, for Members who meet the DHCS-defined criteria for one of the following:

(i) Pregnancy, Postpartum, and Birth Equity Population of Focus (who are subject to racial and ethnic disparities).

2.43.2 Provider as an ECM Provider. Provider shall be responsible for providing ECM services as the Member's ECM Provider. ECM Provider shall ensure its systems and infrastructure are in place to provide ECM services to ECM Members. ECM Provider shall implement ECM in compliance with this Contract and CalOptima Policies.

2.43.3 ECM Provider Requirements. Provider shall satisfy the ECM Provider requirements, as set forth in CalOptima Policies and as follows:

2.43.3.1 ECM Provider shall be experienced in serving the ECM Population(s) of Focus to which Provider will provide ECM services and shall have experience and expertise with the services it will provide.

2.43.3.2 ECM Provider shall comply with all applicable State of California ("State") and federal laws and regulations and all ECM requirements in the contract between DHCS and CalOptima for ECM and Community Supports ("DHCS Contract") and associated guidance.

2.43.3.3 ECM Provider shall have the capacity to provide culturally appropriate and timely in-person care management activities, including accompanying Members to critical appointments when necessary. ECM Provider shall be able to communicate in culturally and linguistically appropriate and accessible ways.

2.43.3.4 ECM Provider shall have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health providers, specialists, and other entities, including Community Supports Providers, to coordinate care as appropriate to each Member.

2.43.3.5 ECM Provider shall use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of an ECM Member care plan that can be shared with other providers and organizations involved in each ECM Member's care. Care management documentation systems may include certified electronic health record technology, or other documentation tools that can: document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; and gather information from other

sources to identify Member needs and support care team coordination and communication and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).

2.43.3.6 If a State-level enrollment pathway exists, ECM Provider shall enroll as a Medi-Cal provider, pursuant to relevant DHCS All Plan Letters ("APLs"), including APL 19-004: Provider Credentialing/ Recredentialing and Screening/Enrollment. If APL 19-004 does not apply to ECM Provider, ECM Provider shall comply with CalOptima's process for vetting the ECM Provider, which may extend to individuals employed by or delivering services on behalf of the ECM Provider, to ensure it can meet the capabilities and standards required to provide ECM services.

2.43.4 Identifying Members for ECM. Provider shall proactively identify Members who would benefit from ECM and send a request to CalOptima to determine if the identified Members are eligible for ECM, consistent with CalOptima's Policies.

2.43.5 Member Assignment to ECM Provider.

2.43.5.1 CalOptima shall be responsible for making ECM authorization determinations for Members in accordance with applicable CalOptima Policies.

2.43.5.2 Provider shall serve as the ECM Provider for all ECM Members assigned by CalOptima to Provider for ECM services. ECM Provider shall immediately alert CalOptima if ECM Provider does not have the capacity to accept an ECM Member assignment.

2.43.6 ECM Provider Staffing. At all times, ECM Provider shall have adequate staff to ensure its ability to carry out responsibilities for each assigned ECM Member consistent with this Contract, CalOptima Policies, DHCS ECM Provider Standard Terms and Conditions, the DHCS Contract, and any other related DHCS guidance.

2.43.7 Initiating Delivery of ECM. ECM Provider shall obtain, document, and manage Member authorization for the sharing of personally identifiable information between CalOptima and ECM Provider, any Community Supports Providers, and other providers involved in the provision of Member care, to the extent required by State and federal law.

2.43.7.1 When State or federal law requires authorization for data sharing, ECM Provider shall communicate that it has obtained Member authorization for such data sharing back to CalOptima.

2.43.7.2 ECM Provider shall notify CalOptima to discontinue ECM under the following circumstances: (i) Member has met their care plan goals for ECM; (ii) Member is ready to transition to a lower level of care; (iii) Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or (iv) ECM Provider has not had any contact with the Member after three (3) attempts.

2.43.7.3 When ECM is discontinued, or is set to be discontinued for a Member, CalOptima is responsible for sending a notice of action notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is informed of their right to appeal and the appeals process. ECM Provider shall communicate to the Member other benefits or programs that may be available to the Member, as applicable (e.g., Complex Case Management, Basic PHM, etc.).

2.43.8 ECM Requirements and Core Service Components of ECM. ECM Provider shall ensure ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Medi-Cal

Members assigned to the Provider. ECM Provider shall ensure the approach is person-centered, goal-oriented, and culturally appropriate.

2.43.8.1 Subject to all applicable requirements set forth in this Contract (including, but not limited to, subcontracting requirements), if the ECM Provider subcontracts with other entities to administer ECM services, ECM Provider shall ensure its Subcontracts with each entity bind the entities to the terms and conditions set forth in this Section 2.43 and CalOptima Policies and that its Subcontractors comply with all requirements in DHCS ECM Provider Standard Terms and Conditions and the DHCS Contract. Notwithstanding any subcontracting arrangements, ECM Provider shall remain responsible and accountable for any subcontracted ECM functions.

2.43.8.2 ECM Provider shall: (i) Ensure each Member receiving ECM has a Lead Care Manager; (ii) coordinate across all sources of care management if an ECM Member is receiving care management from multiple sources; (iii) notify CalOptima to ensure non-duplication of services if an ECM Member is receiving care management or duplication of services from multiple sources; and (iv) follow CalOptima's instructions and participate in efforts to ensure ECM and other care management services are not duplicative.

2.43.8.3 ECM Provider shall collaborate with area hospitals, primary care providers (when not serving as the ECM Provider), behavioral health providers, specialists, dental providers, providers of services for LTSS and other associated entities, such as Community Supports Providers, as appropriate, to coordinate ECM services for Members.

2.43.8.4 ECM Provider shall provide the following core service components of ECM to each assigned ECM Member in compliance with CalOptima Policies GG.1354: Enhanced Care Management – Eligibility and Outreach and GG.1353: Enhanced Care Management Service Delivery: (i) Outreach and engagement of Members into ECM; (ii) comprehensive assessment and care management plan; (iii) enhanced coordination of care; (iv) health promotion; (v) comprehensive transitional care; (vi) Member and family supports; and (vii) coordination of and referral to community and social support services.

2.43.8.5 ECM Provider shall ensure the establishment of an ECM Care Team and a communication process between Members' ECM Care Team participants related to services being rendered, in accordance with CalOptima Policies.

2.43.8.6 ECM Provider shall complete a health needs assessment and develop a comprehensive, individualized, person-centered care plan for each ECM Member. ECM Provider shall ensure case conferences are conducted by the ECM Care Team and the ECM Member's health needs assessment and care plan are updated as necessary.

2.43.9 Training. ECM Provider shall participate in all mandatory, provider-focused ECM training and technical assistance provided by CalOptima, including in-person sessions, webinars, and/or calls, as necessary. ECM Provider shall ensure that its staff who will be delivering ECM services complete training required by CalOptima and DHCS prior to participating in the administration of the ECM services.

2.43.10 Data Sharing to Support ECM. CalOptima and ECM Provider agree to exchange available information and data as required by DHCS and CalOptima Policies, including but not limited to notification of hospital emergency department visits, inpatient admissions and discharges, and health history of ECM Members. CalOptima and ECM Provider shall conduct such information and data sharing in compliance with all applicable Health Insurance Portability and Accountability

Act ("HIPAA") requirements (including the implementing regulations and applying the minimum necessary standard when applicable), and other federal and State laws and regulations, including the California Confidentiality of Medical Information Act. Further, ECM Provider shall establish and maintain a data-sharing agreement with other providers that is compliant with all federal and State laws and regulations as necessary. If applicable laws and/or regulations require an ECM Member's valid authorization for release of health information and a legal exception does not apply, ECM Provider may not release such information without the ECM Member's valid authorization.

2.43.10.1 CalOptima will provide to ECM Provider the following data at the time of assignment and periodically thereafter, and following DHCS guidance for data sharing where applicable: (i) Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to Provider; (ii) non-duplicative Encounter Data and/or claims data, as appropriate; (iii) non-duplicative physical, behavioral, administrative and social determinants of health data (e.g., Homeless Management Information System (HMIS) data) for all assigned Members, as available; and (iv) reports of performance on quality measures and/or metrics, as requested.

2.43.11 Claims Submission and Reporting. ECM Provider shall submit claims for the provision of ECM-related services to CalOptima using the national standard specifications and code sets defined by DHCS. If ECM Provider is unable to submit claims to CalOptima for ECM-related services using the national standard specifications and DHCS-defined code sets, ECM Provider shall submit an invoice to CalOptima with a minimum set of data elements (to be defined by DHCS) necessary for CalOptima to convert the invoice to an encounter for submission to DHCS.

2.43.12 Quality and Oversight. ECM Provider acknowledges that CalOptima will conduct oversight of ECM Provider's participation in ECM to ensure the quality of ECM and ongoing compliance with program requirements, which may include audits and/or corrective actions. ECM Provider shall respond to all requests from CalOptima for information and documentation to permit ongoing monitoring of ECM.

2.43.13 ECM Data and Reports. ECM Provider shall submit to CalOptima complete, accurate, and timely ECM data and reports in the manner and form acceptable to CalOptima as required by CalOptima Policies or otherwise required by DHCS in order for CalOptima to monitor and meet the following: (i) Performance targets; and (ii) CalOptima's data reporting requirements to DHCS.

2.43.14 ECM Provider's Agent Qualifications. ECM Provider shall verify that the qualifications of all agents (including ECM Provider staff) providing ECM services under this Contract comply with the requirements of this Contract, CalOptima Policies, and DHCS guidance. In addition, for agents that enter into Members' homes or have face-to-face interactions with Members, ECM Provider shall also conduct background investigations, including, but not limited to, county, state, and federal criminal history and abuse registry screening. ECM Provider shall comply with all applicable laws in conducting background investigations and shall exclude unqualified agents from providing services under this Contract.

8. Attachment A "Covered Services" shall be deleted in its entirety and replaced with the new Attachment A "Covered Services", which is attached to this Amendment and incorporated into the Contract by this reference.

9. Attachment A "ENHANCED CARE MANAGEMENT SERVICES SHEDULE" shall be added to the Contract and is attached hereto and incorporated herein.

10. Attachment C-1, COMPENSATION FOR ECM SERVICES, shall be added to the Contract and is attached hereto and incorporated herein.

CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue 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. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR PROVIDER:	FOR CALOPTIMA:
{{_es_:signer1:signature}}	{{_es_:signer2:signature}}
Signature	Signature
{{*Name_es_:signer1 }}	{{N_es_:signer2:fullname }}
Print Name	Print Name
{{*_es_:signer1:title }}	{{*_es_:signer2:title }}
Title	Title
{{*_es_:signer1:date }}	{{*_es_:signer2:date }}
Date	Date

ATTACHMENT A
COVERED SERVICES
ARTICLE 1
CALOPTIMA PROGRAMS

1.1 CalOptima Programs. Provider shall furnish Covered Services to eligible Members in the following CalOptima Programs:

__X__ Medi-Cal Program

__X__ OneCare (DSNP Medicare Advantage Program)

ARTICLE 2
SERVICES

2.1 Scope of Covered Services. "Covered Services", as referred to in this Contract, means the services described in each of the schedules to this Attachment A. The schedules to this Attachment A are subject to DHCS's Community Supports Policy Guide or ECM Policy Guide, as applicable, which DHCS may update from time to time. CalOptima may unilaterally amend the schedules in Attachment A, upon notice to Provider, to comply with any DHCS revisions to the Community Supports Policy Guide or ECM Policy Guide as applicable.

ATTACHMENT A
ENHANCED CARE MANAGEMENT SERVICES SCHEDULE

ECM Provider has primary responsibility and agrees to coordinate all primary, acute, behavioral, developmental, oral, social needs, and long-term services and supports ("LTSS") for assigned ECM Members that have been authorized by CalOptima to receive ECM services.

ECM Provider will provide the core service components of ECM to each assigned Member in compliance with CalOptima Policies, including Policies GG 1353, 1354, and 1356, and most current version of the DHCS ECM Policy Guide.

1. ECM Provider shall conduct outreach and engagement of assigned Members into ECM in compliance with CalOptima Policies.

2. Provider shall conduct a comprehensive assessment and develop a care management plan, which shall include:

    a. Engaging with each ECM Member (and/or their parent, caregiver, guardian) authorized to receive ECM primarily through in-person contact.
        i. When in-person communication is unavailable or does not meet the needs of the ECM Member, ECM Provider shall use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with ECM Member (and/or their parent, caregiver, guardian) choice.
    b. Identify necessary clinical and non-clinical resources that may be needed to appropriately assess ECM Member health status and gaps in care and that may be needed to inform the development of an individualized care management plan.
    c. Developing a comprehensive, individualized, person-centered care plan by working with the ECM Member and/or their parent, guardian, authorized representative, caregiver, and/or authorized support person(s) as appropriate to prioritize, address, and communicate strengths, risks, needs, and goals. The care plan must also leverage ECM Member strengths and preferences and make recommendations for service needs.
    d. Incorporating into the ECM Member's care plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, substance use disorder, LTSS, oral health, palliative care, necessary community-based and social services, and housing.
    e. Ensuring the care plan is reassessed at a frequency appropriate for the ECM Member's individual progress or changes in needs and/or as identified in the care management plan.
    f. Ensuring the care management plan is reviewed, maintained and updated under appropriate clinical oversight.

3. Provider shall conduct enhanced coordination of care services necessary to implement the care plan, which shall include:

    a. Organizing patient care activities, as laid out in the care management plan, sharing information with those involved as part of the ECM Member's multi-disciplinary care team, and implementing activities identified in the ECM Member's care management plan.
    b. Maintaining regular contact with all providers identified as a part of the ECM Member's multi-disciplinary care team whose input is necessary for successful implementation of ECM Member goals and needs. The ECM Lead Care Manager is responsible for ensuring the ECM Member has an assigned PCP and that they are engaging with that PCP for appropriate care.
    c. Ensuring care is continuous and integrated among all service providers and referring to and following up with ECM Member's primary care, physical and developmental health, mental health, substance use disorder treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, providers as needed.
    d. Providing support to engage the ECM Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical

appointments, and identifying and helping to address other barriers to ECM Member engagement in treatment.

e. Timely communicating the ECM Member's needs and preferences to the ECM Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care.
f. Ensuring ECM Provider has regular contact with the ECM Member and/or their parent, authorized representative, guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the ECM Member's care management plan.

4. ECM Provider must ensure that the assigned Lead Care Manager is responsible for ensuring that Basic PHM is in place as part of the ECM Member's care management. Basic PHM includes health promotion activities to encourage and support ECM Members receiving ECM to make lifestyle choices based on healthy behaviors, with the goal of motivating ECM Members to successfully monitor and manage their health. Health promotion activities shall adhere to federal care coordination and continuity of care requirements set forth in 42 CFR §438.208(b) and shall include:

    a. Working with ECM Members to identify and build on successes and potential family and/or support networks.
    b. Providing services to encourage and support ECM Members to make lifestyle choices based on healthy behavior, with the goal of supporting ECM Members' ability to successfully monitor and manage their health.
    c. Supporting ECM Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

5. Provider shall conduct transitional care services, which are services intended to support ECM Members and their families and/or support networks as ECM Members transfer from one setting or level of care to another, including discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities to home or community-based settings, Community Support, post-acute care facilities, or LTC settings. Transitional care services shall include:

    a. Providing information to the hospital discharge planners or discharging facility to collaborate on behalf of the ECM member in a timely manner and so that the ECM Member does not receive two different discharge planning documents;
    b. Reviewing admissions, discharge, or transfer feed data information provided to ECM Provider to provide transitional care services.
    c. Developing strategies to reduce avoidable ECM Member admissions and readmissions across all ECM Members receiving ECM;
    d. For ECM Members who are experiencing, or who are likely to experience a care transition:
        i. Developing and regularly updating a transition-of-care plan for the ECM Member.
        ii. Ensuring the completion of discharge risk assessment and coordinating any follow-up provider appointments and support services to facilitate safe and appropriate transitions from one setting or level of care to another.
        iii. Coordinating medication review/reconciliation.
        iv. Providing adherence support and referral to appropriate services.

6. Provider shall conduct ECM Member and family supports activities that ensure the ECM Member and family/support are knowledgeable about the ECM Member's condition in order to improve the ECM Member's adherence to treatment and medication management. ECM Member and family supports activities shall include:

    a. Documenting an ECM Member's designated parent or other family member(s), authorized representative, guardian, caregiver, and/or authorized support person(s) and ensuring all appropriate authorizations are in place to ensure effective communication

between ECM Provider, CalOptima, the ECM Member, and/or the ECM Member's authorized parent, family member(s), guardian, caregiver, and/or authorized support person(s), as applicable.

b. Activities to ensure the ECM Member and/or their parent, other family member(s), authorized representative, guardian, caregiver, and/or other authorized support person(s) are knowledgeable about the ECM Member's condition(s) with the overall goal of improving the ECM Member's care planning and follow-up, adherence to treatment and medication management, in accordance with federal, State and local privacy and confidentiality laws.
c. Serving as the primary point of contact for the ECM Member and/or parent, other family member(s), authorized representative, guardian, caregiver, and/or authorized support person(s).
d. Identifying supports needed for the ECM Member and/or their parent, other family member(s), authorized representative, guardian, caregiver, and/or authorized support person(s) to manage the ECM Member's condition and assist them in accessing needed support services.
e. Providing for appropriate education of the ECM Member and/or their parent, other family member(s), authorized representative, guardian, caregiver, and/or authorized support person(s) about care instructions for the ECM Member.
f. Ensuring that the ECM Member, parent, caregiver, guardian, other family member(s), and/or other authorized support person(s) has a copy of their care management plan and information about how to request updates.

7. Provider shall conduct coordination of and referral to community and social support services, which shall include:

a. Determining appropriate services to meet the needs of ECM Members, including services that address social determinants of health needs, including housing, and services offered by CalOptima as Community Supports; and
b. Coordinating and referring ECM Members to available community resources and following up with ECM Members and/or their parent, caregiver, guardian, or other authorized support person(s) to ensure services were rendered (i.e., "closed loop referrals").

ATTACHMENT C-1
COMPENSATION FOR ECM SERVICES

Effective @@Amendment Effective Date@@, subject to approval by DHCS, CalOptima shall make an ECM Supplemental Payment (as defined in Section 1.1 below) to Provider for ECM services provided to an ECM Member, in accordance with the terms and conditions of the Contract, DHCS requirements, and CalOptima Policies, including CalOptima Policy FF.4002, which is incorporated into the Contract by this reference.

1. ECM Supplemental Payment.

   1.1 CalOptima shall pay Provider during the term of the Contract the ECM Supplemental Payment rate of [redacted] PMPM for each Member who receives two (2) or more hours of ECM services in a given month as identified by eight (8) or more units, subject to ECM Provider's compliance with all of the following conditions:

   - Member is identified as an ECM-eligible Member, as determined by CalOptima based on DHCS ECM eligibility criteria and in accordance with CalOptima Policy GG.1354;
   - Member is authorized by CalOptima to receive ECM services;
   - Member receives one of the ECM core service components (as set forth in Section 2.43 of the Contract and further outlined in Attachment A) in the prior month;
   - ECM Provider bills and reports ECM services to CalOptima consistent with CalOptima Policies, including CalOptima Policy FF.4002, and DHCS requirements;
   - If applicable, the Provider paid the provider delegated by Provider to render the ECM services; and
   - ECM Provider authorized such ECM services, if delegated to another provider.

   1.2 For purposes of this Section 1, "PMPM" means an all-inclusive case rate that applies whenever Provider, as the ECM Provider, has provided the minimum level of service payable to an ECM Member. This rate is paid on the basis of submitted claims and is not to be considered a capitation payment.

2. Provider shall submit ECM billing data for the ECM Services Supplemental Payment in accordance with CalOptima Policy FF.4002.

3. Upon validation of the ECM billing data and in accordance with CalOptima Policy FF.4002, CalOptima shall pay ECM Provider the ECM Supplemental Payment within ninety (90) percent of all clean claims within thirty (30) calendar days of the date of receipt and ninety-nine (99) percent of all clean claims within ninety (90) calendar days of the date of receipt. The date of receipt shall be the date CalOptima receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

4. In addition to Section 4.8 of this Contract, Provider agrees to cooperate and comply with CalOptima's recovery of any overpayment of ECM Supplemental Payment, in accordance with CalOptima Policy FF.4002.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

33. Authorize Amendments to the Medi-Cal Mental Health Non-Applied Behavioral Analysis and Applied Behavioral Analysis Provider Contracts

Contacts

Carmen Katsarov, LPCC, CCM, Executive Director, Behavioral Health Integration (714) 796-6168
Michael Gomez, Executive Director, Network Operations (714) 347-3292

Recommended Actions

1. Authorize amendments to the Medi-Cal Professional Services Contract for Mental Health Non-Applied Behavioral Analysis services to reflect reimbursement rate increases effective July 1, 2023; and
2. Authorize amendments to the Medi-Cal Professional Services Contract for Applied Behavioral Analysis services to reflect reimbursement rate increases effective July 1, 2023.

Background and Discussion

On January 1, 2018, CalOptima Health assumed responsibility for Mental Health Non-Applied Behavioral Analysis (Non-ABA) and Applied Behavioral Analysis (ABA) services from its external vendor and established its own in-house network of contracted providers. Since assuming the provision of behavioral health services in 2018, CalOptima Health has made it a priority to take steps to ensure continuous access to quality behavioral health care for its members. This includes regular examination of market equivalency to ensure Mental Health Non-ABA and ABA provider compensation is competitive and conducive to maintaining a robust network of behavioral health providers.

On August 4, 2022, the Board authorized rate increases for Medi-Cal ABA contracts effective October 1, 2022, with an annual expenditure of $19.9 million. On October 6, 2022, the Board authorized a rate increase for Mental Health Non-ABA contracts effective January 1, 2023, with an annual expenditure of $4.3 million.

CalOptima Health has since continued to assess market equivalency with Medi-Cal organizations and payers. Comparative analysis shows that an additional reimbursement rate increase is necessary to remain competitive in the market and ensure CalOptima Health's members have continued access to quality care. To ensure standardization and equity for Medi-Cal Mental Health Non-ABA and ABA providers and improved access to services, staff requests the Board authorize amendments to the Professional Services Contracts reflecting an additional rate increase, effective July 1, 2023.

The proposed amendments will increase rates for Medi-Cal Mental Health Non-ABA services by an average of 6.1%, effective July 1, 2023. Rate increases will vary by provider, impacted by their corresponding service mix and ranging from 0% to approximately 38% above current funding.

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The proposed amendments will increase rates for Medi-Cal ABA services by an average of 7.0%, effective July 1, 2023. Rate increases will vary by service type, ranging from 0% to approximately 24% above current funding.

These actions will support continued quality care for CalOptima Health's members.

Fiscal Impact

Management has included medical expenses associated with the rate increase to Medi-Cal Mental Health Non-ABA provider contracts effective July 1, 2023, in the proposed CalOptima Health Fiscal Year (FY) 2023-24 Operating Budget. The estimated annual fiscal impact is approximately $1.8 million.

Management has included medical expenses associated with the rate increase to Medi-Cal ABA provider contracts, effective July 1, 2023, in the proposed CalOptima Health Fiscal Year (FY) 2023-24 Operating Budget. The estimated annual fiscal impact is approximately $6.6 million.

Rationale for Recommendation

The rate increases to the Mental Health Non-ABA and ABA provider contracts will help support continued access to care and quality services for CalOptima Health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Draft amendment to Professional Services Contract for Mental Health Non-ABA providers
2. Draft amendment to Professional Services Contract for Applied Behavioral Analysis providers

Board Action(s)

Board Meeting Dates	Action	Term	Not to Exceed Amount
August 4,2022	Approved		
October 6,2022	Approved		

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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AMENDMENT X TO

PROFESSIONAL SERVICES CONTRACT

This Amendment X to the Professional Services Contract ("**Amendment**") is effective as of July 1, 2023 ("**Effective Date**"), by and between Orange County Health Authority, a Public Agency, dba CalOptima Health ("**CalOptima**"), and ABC Inc. ("**Professional**"), with respect to the following:

RECITALS

A. CalOptima and Professional entered into a Professional Services Contract, by which Professional has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Professional desire to revise the compensation rates for certain services.

C. CalOptima and Professional desire to amend this Contract on the terms and conditions set forth herein.

NOW, THEREFORE, the parties agree as follows:

1. Attachment B, Confidential Compensation Terms, shall be deleted in its entirety and replaced with a new Attachment B, Compensation, attached hereto and incorporated herein.

CONTRACT REMAINS IN FULL FORCE AND EFFECT. Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue 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. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and Professional have executed this Amendment.

For Professional:	For CalOptima:
{{_es_:signer1:signature}}	{{_es_:signer2:signature}}
Signature	Signature
{{*Name_es_:signer1 }}	{{N_es_:signer2:fullname }}
Print Name	Print Name
{{*_es_:signer1:title }}	{{*_es_:signer2:title }}
Title	Title
{{*_es_:signer1:date }}	{{*_es_:signer2:date }}
Date	Date

ATTACHMENT B

COMPENSATION

CalOptima shall reimburse Professional and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

I. MEDI-CAL PROGRAM

For Covered Services provided to referred Medi-Cal Members, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

CalOptima

Medi-Cal Mental Health Fee Schedule

		Physician	Psychologist	Master's Level	Nurse Practitioner, Clinical Nurse Specialist, or Physician Assistant.	Registered Psychological Associate, Associate Clinical Social Worker, Associate Marriage and Family Therapist, Associate Professional Clinical Counselor
CPT	**Procedure Description**	**AF Modifier**	**AH Modifier**	**AJ or HO Modifier**	**AS Modifier**	**HL Modifier**
90785	PSYCHOTHERAPY COMPLEX INTERACTIVE	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90792	PSYCHIATRIC DIAGNOSTIC EVAL W/MEDICAL SERVICES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90832	PSYCHOTHERAPY W/PATIENT 30 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90833	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 30 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

90834	PSYCHOTHERAPY W/PATIENT 45 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90837	PSYCHOTHERAPY W/PATIENT 60 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90839	PSYCHOTHERAPY FOR CRISIS INITIAL 60 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90840	PSYCHOTHERAPY FOR CRISIS EACH ADDL 30 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90846	FAMILY PSYCHOTHERAPY W/O PATIENT PRESENT 50 MINS	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90847	FAMILY PSYCHOTHERAPY W/PATIENT PRESENT 50 MINS	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90849	MULTIPLE FAMILY GROUP PSYCHOTHERAPY	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90853	GROUP PSYCHOTHERAPY	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
90880	HYPNOTHERAPY	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96110	DEVELOPMENTAL SCREEN W/SCORING & DOC STD INSTRM	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96112	DEVELOPMENTAL TST ADMIN PHYS/QHP 1ST HOUR	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96113	DEVELOPMENTAL TST ADMIN PHYS/QHP EA ADDL 30 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96116	NEUROBEHAVIORAL STATUS XM PHYS/QHP 1ST HOUR	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96121	NEUROBEHAVIORAL STATUS XM PHYS/QHP EA ADDL HOUR	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

96127	BEHAV ASSMT W/SCORE & DOCD/STAND INSTRUMENT	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96130	PSYCHOLOGICAL TST EVAL SVC PHYS/QHP FIRST HOUR	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96131	PSYCHOLOGICAL TST EVAL SVC PHYS/QHP EA ADDL HOUR	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96132	NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP 1ST HOUR	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96133	NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP EA ADDL HR	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96136	PSYL/NRPSYCL TST PHYS/QHP 2+ TST 1ST 30 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96137	PSYCL/NRPSYCL TST PHYS/QHP 2+ TST EA ADDL 30 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96138	PSYCL/NRPSYCL TST TECH 2+ TST 1ST 30 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96139	PSYCL/NRPSYCL TST TECH 2+ TST EA ADDL 30 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96146	PSYCL/NRPSYCL TST ELEC PLATFORM AUTO RESULT	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
96156	HEALTH BEHAVIOR ASSESSMENT/RE-ASSESSMENT	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99203	OFFICE/OUTPATIENT NEW LOW MDM 30-44 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99204	OFFICE/OUTPATIENT NEW MODERATE MDM 45-59 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

99205	OFFICE/OUTPATIENT NEW HIGH MDM 60-74 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99211	OFFICE/OUTPATIENT EST PT MAY NOT REQ PHYS/QHP	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99212	OFFICE/OUTPATIENT ESTABLISHED SF MDM 10-19 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99213	OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20-29 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99214	OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30-39 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99215	OFFICE/OUTPATIENT ESTABLISHED HIGH MDM 40-54 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99241	OFFICE CONSULTATION NEW/ESTAB PATIENT 15 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99242	OFFICE CONSULTATION NEW/ESTAB PATIENT 30 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99243	OFFICE CONSULTATION NEW/ESTAB PATIENT 40 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99244	OFFICE CONSULTATION NEW/ESTAB PATIENT 60 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99304	INITIAL NURSING FACILITY CARE/DAY 25 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99305	INITIAL NURSING FACILITY CARE/DAY 35 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99306	INITIAL NURSING FACILITY CARE/DAY 45 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

99308	SBSQ NURSING FACIL CARE/DAY MINOR COMPLJ 15 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99309	SBSQ NURSING FACIL CARE/DAY NEW PROBLEM 25 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99327	DOMICIL/REST HOME NEW PT VISIT HI SEVER 60 MIN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99348	HOME VISIT EST PT LOW-MOD SEVERITY 25 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99349	HOME VISIT EST PT MOD-HI SEVERITY 40 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99406	TOBACCO USE CESSATION INTERMEDIATE 3-10 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
99407	TOBACCO USE CESSATION INTENSIVE >10 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
G0442	ANNUAL ALCOHOL MISUSE SCREENING 15 MINUTES	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
G9919	SCREENING PERF & POS & PROVISION RECOMMENDATIONS	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
G9920	SCREENING PERFORMED AND NEGATIVE	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

NOTES:

1. Discipline levels will vary from state to state. N/B indicates a non-billable service for this discipline level.

2. Reimbursement is based on the treating provider's licensure, certification, and CalOptima credentialing requirements for that discipline, and is not based on provider's academic credentials alone.

3. Rates include reimbursement for travel time and expense.

4. Rates for all services are subject to the provisions and limitations of the member's benefit plan including authorization requirements. Nothing in this schedule should be construed as altering member's benefits.

5. The coding definitions (e.g., DRGs, ICD Codes, Procedures, CPT Codes) assigned in this Agreement shall be considered automatically updated based on revised codes and newly introduced codes consistent with guidance provided from the organization(s) responsible for code set updates (e.g., DHS, AMA, WHO, etc.), as applicable, and consistent with industry standards. If codes are changed by addition or deletion as stated in the current year's Coding Publications, it is understood that services will automatically convert to the new code(s) that best apply to the service.

6. Any CPT or HCPCS code not contained in the above fee schedule at the time of service shall default at one hundred percent (100%) of the Current CalOptima Medi-Cal Fee Schedule, as defined in CalOptima Policy for those services. Medi-Cal billing rules and payment and authorization policies and guidelines for billing and payment will apply.

7. Claims not submitted with the appropriate modifier are not reimbursable and will be denied.

II. ONECARE AND ONE CARE CONNECT PROGRAMS

Not Applicable to this Contract

III. PACE PROGRAM

Not Applicable to this Contract

IV. PAYMENT PROCEDURES

1. CalOptima agrees to grant Professional access to Member management information systems. Professional agrees to verify each Member's eligibility to receive Covered Services on the date of service.

2. Billing and Claims Submission. Professional shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

3. Prompt Payment. CalOptima shall make payments to Professional in the time and manner set forth in CalOptima Policies and Procedures.

4. Claim Completion and Accuracy. Professional shall be responsible for the completion and accuracy of all Claims submitted, whether on paper forms or electronically, including claims submitted for the Professional by other parties. Use of a billing agent does not abrogate Professional's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Professional acknowledges that Professional 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.

5. Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Professional notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.

6. Coordination of Benefits (COB). Professional shall coordinate benefits with other programs or entitlements recognizing where Other Health Coverage (OHC) is primary coverage in accordance with CalOptima Program requirements. Professional acknowledges that Medi-Cal is the payor of last resort.

7. Crossover Claims – Dual Eligible Members. "Crossover Claims" are claims for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or other health care coverage (OHC) is the Primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's Programs. California law limits Medi-Cal's reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum allowed for similar services (Refer to Welfare and Institutions Code, Section 14109.5.).

   "Dual Eligible Members" are members who are eligible for both Medicare or other health care coverage (OHC) and Medi-Cal benefits.

   The Medi-Cal reimbursement rates in this contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims payment CalOptima will reimburse in accordance with CalOptima Policies, and state and federal regulations.

8. Member Financial Protections. Professional shall comply with Member financial protections as follows:

   8.1 Professional 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 Professional for any amounts which are owed by, or are the obligation of, CalOptima.

   8.2 Professional agrees to hold Member harmless and not liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Professional may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Professional will:

      1) accept the plan payment as payment in full, or

      2) bill the appropriate State source.

   8.3 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or the Professional's insolvency, or breach of this contract by CalOptima, shall the Professional, or any of its Practitioners, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Professional may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

   8.4 This provision does not prohibit Professional from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment 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 prior to rendering such services.

8.5 Upon receiving notice of Professional invoicing or balance billing a Member for the difference between the Professional's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Professional or take other action as provided in this Contract.

This Section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members 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 Members. This Section shall supersede any oral or written contrary agreement now existing or hereafter entered into between Professional and its Practitioners. Language to ensure the foregoing shall be included in all of Professional's Subcontracts.

9. Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Professional, reduce payment to Professional under this Attachment B – PACE, CALMEDICONNECT and MEDICARE ADVANTAGE, by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the Term.

AMENDMENT X TO

PROFESSIONAL SERVICES CONTRACT

This Amendment X to the Professional Services Contract ("**Amendment**") is effective as of July 1, 2023 ("**Effective Date**"), by and between Orange County Health Authority, a Public Agency, dba CalOptima Health ("**CalOptima**"), and ABC Inc. ("**Professional**"), with respect to the following:

RECITALS

A. CalOptima and Professional entered into a Professional Services Contract, by which Professional has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Professional desire to revise the compensation rates for certain services.

C. CalOptima and Professional desire to amend this Contract on the terms and conditions set forth herein.

NOW, THEREFORE, the parties agree as follows:

1. Attachment B, Confidential Compensation Terms, shall be deleted in its entirety and replaced with a new Attachment B, Confidential Compensation Terms attached hereto and incorporated herein.

CONTRACT REMAINS IN FULL FORCE AND EFFECT. Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue 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. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and Professional have executed this Amendment.

FOR PROFESSIONAL:	FOR CALOPTIMA:
{{_es_:signer1:signature}}	{{_es_:signer2:signature}}
Signature	Signature
{{*Name_es_:signer1 }}	{{N_es_:signer2:fullname }}
Print Name	Print Name
{{*_es_:signer1:title }}	{{*_es_:signer2:title }}
Title	Title
{{*_es_:signer1:date }}	{{*_es_:signer2:date }}
Date	Date

ATTACHMENT B

CONFIDENTIAL COMPENSATION TERMS

I. MEDI-CAL PROGRAM

For Covered Services provided to referred Medi-Cal Members, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

CalOptima ABA Fee Schedule Autism Related Services

HCPCS Code	Procedure Description	Paraprofessional or Registered Behavior Technician Modifier Rates	Associate Behavioral Analyst (BCaBA), or Behavior Management Assistant Modifier Rates	Board Certified Behavior Analyst (BCBA), or Behavior Management Consultant/ Licensed Health Professional Modifier Rates	Board Certified Behavior Analyst (BCBA) Modifier Rates
H0031	Functional Behavioral Assessment by BCBA, per 15 min	[redacted]	[redacted]	[redacted]	[redacted]
H0032	Case oversight and management of treatment team, per 15 min	[redacted]	[redacted]	[redacted]	[redacted]
H2019	Direct Applied Behavior Analysis, per 15 min	[redacted]	[redacted]	[redacted]	[redacted]
S5110	Home care training, family, per 15 min	[redacted]	[redacted]	[redacted]	[redacted]
H2014	Social Skills group, per 15 min	[redacted]	[redacted]	[redacted]	[redacted]
H2014	Skills training and development, per 15 min	[redacted]	[redacted]	[redacted]	[redacted]
S5108	Home care training to home care, client, per 15 min	[redacted]	[redacted]	[redacted]	[redacted]

Modifier	Description
HO	Board Certified Behavior Analyst (BCBA or BCBA-D) or Licensed Health Professional, which is a Psychologist, Clinical Social Worker, Marriage and Family Therapist, or other licensed professional whose California licensure permits the design and/or implementation of behavior modification intervention services. Additionally, must have 12 twelve semester units in ABA, and 2 years experience designing and implementing behavior modification intervention services.
HN	Associate Behavioral Analyst (BCaBA), or Behavior Management Assistant
HM	Paraprofessional or Registered Behavior Technician
HQ	Group Setting

NOTES:

1. Reimbursement is based on the treating provider's licensure, certification, and CalOptima credentialing requirements for that discipline, and is not based on provider's academic credentials alone.
2. Rates include reimbursement for travel time and expense.
3. CPT or HCPCS codes not contained in the above fee schedule are not reimbursable.
4. Professional shall not be reimbursed for services provided to Member if there was no prior authorization received from CalOptima in accordance with Cal Optima Policies and Procedures.
5. The coding definitions (e.g., CPT/HCPCS Codes) assigned in this Agreement shall be considered automatically updated based on revised codes and newly introduced codes consistent with guidance provided from the organization(s) responsible for code set updates (e.g. DHCS, AMA, etc.), as applicable, and consistent with industry standards. If codes are changed by addition or deletion as stated in the current year's Coding Publications, it is understood that services will automatically revert to the new code(s) that best apply to the service.

II. PACE PROGRAM

Not Applicable to this Contract

III. ONE CARE AND ONECARE CONNECT PROGRAM

Not Applicable to this Contract

IV. PAYMENT PROCEDURES

1. CalOptima agrees to grant Professional access to Member management information systems. Professional agrees to verify each Member's eligibility to receive Covered Services on the date of service.
2. Billing and Claims Submission. Professional shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.
3. Prompt Payment. CalOptima shall make payments to Professional in the time and manner set forth in CalOptima Policies and Procedures.
4. Claim Completion and Accuracy. Professional shall be responsible for the completion and accuracy of all Claims submitted, whether on paper forms or electronically, including claims submitted for the Professional by other parties. Use of a billing agent does not abrogate Professional's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Professional acknowledges that Professional 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.
5. Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Professional notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.
6. Coordination of Benefits (COB). Professional shall coordinate benefits with other programs or entitlements recognizing where Other Health Coverage (OHC) is primary coverage in accordance with CalOptima Program requirements. Professional acknowledges that Medi-Cal is the payor of last resort.
7. Crossover Claims – Dual Eligible Members. "Crossover Claims are claims for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or other health care coverage (OHC) is the Primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's Programs. California law limits Medi-Cal's reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum allowed for similar services (Refer to Welfare and Institutions Code, Section 14109.5.)

"Dual Eligible Members" are members who are eligible for both Medicare or other health care coverage (OHC) and Medi-Cal benefits.

The Medi-Cal reimbursement rates in this contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims payment CalOptima will reimburse in accordance with CalOptima Policies, and state and federal regulations.

8. Member Financial Protections. Professional shall comply with Member financial protections as follows:

8.1 Professional 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 Professional for any amounts which are owed by, or are the obligation of, CalOptima.

8.2 Professional agrees to hold Member harmless and not liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Professional may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Professional will:

8.2.1 accept the plan payment as payment in full, or

8.2.2 bill the appropriate State source.

8.3 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or the Professional's insolvency, or breach of this contract by CalOptima, shall the Professional, or any of its Practitioners, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Professional may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

8.4 This provision does not prohibit Professional from billing and collecting payment for non- Covered Services if the CalOptima Member agrees to the payment 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 prior to rendering such services.

8.5 Upon receiving notice of Professional invoicing or balance billing a Member for the difference between the Professional's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Professional or take other action as provided in this Contract.

This Section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members 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 Members. This Section shall supersede any oral or written contrary agreement now existing or hereafter entered into between Professional and its Practitioners. Language to ensure the foregoing shall be included in all of Professional's Subcontracts.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
34. Approve Rate Increase for Contracted Medi-Cal Community-Based Adult Services Providers and Authorize Prospective Contract Amendments to Update Payment Rates

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

Recommended Actions
Authorize amendments to the CalOptima Health Ancillary Services Contract with Medi-Cal Community-Based Adult Services providers, effective July 1, 2023, to update payment rates for covered services.

Background and Discussion
Staff requests authorization to update payment rates for Community-Based Adult Services (CBAS) covered services from the current reimbursement rate of 114% of the Medi-Cal fee schedule to 117% of the Medi-Cal fee schedule. CalOptima Health last increased CBAS payment rates by 10% in 2019.

Contracted CBAS centers are crucial network partners for CalOptima Health. The care that CBAS centers provide allows members to live in their homes by providing a safe, stimulating environment for them during the day. This care also results in avoiding premature skilled nursing facility placement. CalOptima Health has received requests for contract rate increases from various CBAS centers, citing increased costs related to providing care to members with higher acuity. Staff recommends increasing rates for CBAS providers and is requesting authorization to amend contracts accordingly.

Fiscal Impact
Management has included medical expenses associated with the updated CBAS payment rates in the proposed CalOptima Health Fiscal Year 2023-24 Operating Budget. The additional annual increase from current rates is approximately $1.93 million.

Rationale for Recommendation
The proposed rate increase and contract amendments will support the stability of CalOptima Health's contracted provider delivery system.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

35. Authorize Assignment of the Restated Medi-Cal and Medicare Health Network Contracts with ARTA Western California Inc. dba Optum and Talbert Medical Group P.C. dba Optum to Monarch Health Plan, Inc.

Contacts

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

Recommended Actions

Authorize assignment of ARTA Western California Inc. dba Optum (ARTA) and Talbert Medical Group P.C. dba Optum (Talbert) Medi-Cal health networks to Monarch Health Plan, Inc. (Monarch), and corresponding contract model changes, effective January 1, 2024, by way of the following actions:

1. Authorize the Chief Executive Officer (CEO) to assign the ARTA and Talbert Shared Risk Group (SRG) contracts to Monarch via the "Consent to Assignment Agreement", which transfers enrollment and converts these entities from shared risk group (SRG) to a health maintenance organization (HMO), effective January 1, 2024;

2. Authorize the CEO to enter into an amended and restated HMO Medi-Cal contract with Monarch on behalf of itself and ARTA and Talbert, effective January 1, 2024; and

3. Authorize the CEO to enter into a restated HMO Medicare Advantage (OneCare) contract with Monarch, on behalf of itself and ARTA and Talbert, effective January 1, 2024.

Background and Discussion

Staff requests authorization to transition ARTA and Talbert from their current SRG risk arrangements to HMO arrangements and to assign ARTA and Talbert's contracts and the corresponding administrative oversight of the new full-risk arrangement to Monarch. These actions require amended and restated Medi-Cal and Medicare contracts for Monarch, on behalf of itself and ARTA and Talbert, for which approval is also being sought. The assignment of ARTA and Talbert to Monarch will happen via the "Consent to Assignment Agreement", which details the terms and obligations of the new arrangement.

Pursuant to ARTA and Talbert's transition to the HMO contract risk arrangement, delegation of all of provider obligations will be fully assumed by ARTA and Talbert, under Monarch's administrative oversight. This will take place subject to successful Department of Managed Health Care (DMHC) approval, and CalOptima Health Board of Directors (Board) approval.

CalOptima Health utilizes three different contract risk models for its Medi-Cal and Medicare programs, each involving varying levels of financial risk: Physician Hospital Consortia (PHC), SRG, and HMO. CalOptima currently contracts with five (5) SRG health networks under its Medi-Cal line of business, which include ARTA and Talbert. Pending approval of this Board action, ARTA and Talbert will serve as Medi-Cal HMO networks starting January 1, 2024. The HMO network is a full risk model under

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which the provider is a single entity that accepts risk for all delegated contracted covered services as a DMHC-licensed entity.

Execution of restated Medi-Cal and Medicare (OneCare) contracts for Monarch via the Consent to Assignment Agreements, will effectively designate Monarch as the administrative entity for the ARTA and Talbert HMO health networks, as of January 1, 2024.

Staff requests Board authorization of the recommended actions for ARTA, Talbert, and Monarch, as applicable, effective January 1, 2024, to implement the changes that will support the new agreement between CalOptima Health and Monarch. These include the change of ARTA and Talbert's risk arrangement from SRG to HMO, authorization of Consent to Assignment Agreements, and execution of amended and restated Medi-Cal and OneCare contracts for Monarch, on behalf of itself and ARTA and Talbert.

Fiscal Impact
The recommended actions have been accounted for in the proposed CalOptima Health Fiscal Year 2023-24 Operating Budget. The additional annual financial impact of the risk model change is estimated at $6.9 million.

Rationale for Recommendation
Authorization of the above actions will support the alignment of ARTA, Talbert, and Monarch under a single contract structure and risk arrangement, effective January 1, 2024.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Board Action
2. Draft Consent to Assignment Agreement – ARTA Western California Inc. dba Optum
3. Draft Consent to Assignment Agreement – Talbert Medical Group P.C. dba Optum
4. Draft HMO Medi-Cal contract for Monarch Health Plan, Inc.
5. Draft HMO Medicare contract for Monarch Health Plan Inc.

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima Health Medi-Cal Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245

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CONSENT TO ASSIGNMENT AGREEMENT

This Consent to Assignment Agreement ("**Agreement**") is made and entered into as of the Assignment Effective Date (as defined below) by and between ARTA Western California, Inc. dba Optum ("**Assignor**"), Monarch Health Plan, Inc. ("**Assignee**"), and Orange County Health Authority dba CalOptima Health ("**CalOptima**"). Assignor, Assignee, and CalOptima may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. Assignor and CalOptima entered into a Medicare Advantage – Physician Group Services Contract, which was effective January 1, 2023, and subsequently amended twice ("**MA Contract**").

B. Section 12.4 of the MA Contract requires Assignor to obtain CalOptima's prior written consent for any assignment of the MA Contract.

C. Assignor and CalOptima entered into a Medi-Cal Physician – Shared Risk Amended and Restated Contract for Health Care Services, which was effective March 1, 2022, and subsequently amended 14 times ("**Medi-Cal Contract**").

D. Section 14.10 of the Medi-Cal Contract requires Assignor to obtain prior written consent from the California Department of Health Care Services ("**DHCS**") and CalOptima for any assignment of the Medi-Cal Contract.

E. Assignor intends to assign the MA Contract and the Medi-Cal Contract to Assignee ("**Assignments**") such that CalOptima's prior written consent is necessary.

F. The Parties desire to enter into the Agreement to obtain CalOptima's prior written consent to the proposed Assignments.

AGREEMENT

NOW, THEREFORE, in consideration of the above Recitals, which are incorporated into the Agreement by this reference, and the mutual promises and covenants contained in this Agreement, the Parties agree as follows:

1. **CalOptima Consent**. Subject to the terms and conditions contained herein, CalOptima consents to the Assignments under Section 12.4 of the MA Contract and Section 14.10 of the Medi-Cal Contract, as of the Assignment Effective Date.

2. **Assignment Obligations**. Assignor and Assignee agree that:

   A. Assignor hereby assigns to Assignee all of Assignor's right, title and interest in and to the MA Contract and Medi-Cal Contract and hereby delegates to Assignee all of its duties and obligations under the MA Contract and Medi-Cal Contract that accrued on or after the Assignment Effective Date, subject to the terms, conditions and provisions of this Agreement. Notwithstanding anything to the contrary contained herein, it is specifically understood and agreed that Assignor's assignment to the Assignee of its rights under the MA Contract and Medi-Cal Contract includes the right to receive any and all payments or consideration due thereunder from CalOptima, notwithstanding the fact that the right to

payments or consideration may have accrued, in whole or part, prior to the Assignment Effective Date.

B. During the terms of the MA Contract and Medi-Cal Contract, Assignor is prohibited from acting or failing to act in any way that interferes with or prevents Assignee from complying with Assignee's obligations under the MA Contract or the Medi-Cal Contract.

C. To induce CalOptima to consent to the Assignments and in consideration of its so doing, Assignee acknowledges receipt of a copy of the fully executed the MA Contract and Medi-Cal Contract and hereby unconditionally assumes, becomes a party to and agrees to perform all the duties and obligations of Assignor arising under the MA Contract and Medi-Cal Contract, as if Assignee had been an original party thereto, on or after the Assignment Effective Date. Notwithstanding anything to the contrary contained herein, Assignee's assumption of Assignor's duties and obligations under the MA Contract and Medi-Cal Contract includes, but is not limited to, any payments or amounts due to CalOptima pursuant to the terms and conditions of the MA Contract and Medi-Cal Contract, notwithstanding the fact that these duties and obligations may have accrued, in whole or in part, prior to the Assignment Effective Date.

D. Assignor is in no way released or discharged from the MA Contract and Medi-Cal Contract or its obligations that accrued prior to the Assignment Effective Date.

3. **Term**. This Agreement shall become effective on the Assignment Effective Date. The "**Assignment Effective Date**" shall be the date that all necessary regulatory approvals have been issued, including approval by DHCS and the California Department of Managed Health Care, and including the subsequent signing of all Parties of the Agreement for an implementation date of January 1, 2024.

4. **Miscellaneous**.

A. Prohibition on Further Assignment. Any further assignment of rights and duties under the MA Contract or the Medi-Cal Contract shall occur only upon the subsequent mutual written agreement of Assignee and CalOptima.

B. Governing Law. This Agreement will be governed by the laws of the State of California.

C. Amendment and Waiver. No amendment, modification, or waiver of any provision of this Agreement shall be effective unless it is in writing and signed by the Parties.

D. Dispute Resolution.

i. *Meet and Confer*. For any dispute arising under or related to this Agreement, the Parties shall use reasonable efforts to meet and confer to 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 any 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 Parties' option, the dispute may proceed immediately to arbitration under Section 4.D.ii.

ii. *Arbitration*. If the Parties are unable to resolve any dispute arising out of or relating to this Agreement under Section 4.D.i, any Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Agreement shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, 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 (2) 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.

iii. *Exclusive Remedy*. With the exception of any dispute that under applicable laws that may not be settled through arbitration, arbitration under Section 4.D.ii is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Agreement that is not resolved through the provider appeals or meet-and-confer processes.

iv. *Waiver*. By agreeing to binding arbitration as set forth in Section 4.D.ii, 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.

E. Counterparts. This Agreement may be executed in two (2) or more counterparts, each of which constitutes an original, but all of which, when taken together, shall constitute but one agreement.

F. Entire Agreement. This Agreement contain the entire understanding between the Parties related to the Assignment and supersedes any prior understandings between the Parties with respect to the subject matter herein.

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Agreement.

ARTA WESTERN CALIFORNIA, INC. DBA OPTUM	ORANGE COUNTY HEALTH AUTHORITY DBA CALOPTIMA HEALTH
By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

MONARCH HEALTH PLAN, INC.
By:
Print Name:
Title: Date:

CONSENT TO ASSIGNMENT AGREEMENT

This Consent to Assignment Agreement ("**Agreement**") is made and entered into as of the Assignment Effective Date (as defined below) by and between Talbert Medical Group, P.C. dba Optum ("**Assignor**"), Monarch Health Plan, Inc. ("**Assignee**"), and Orange County Health Authority dba CalOptima Health ("**CalOptima**"). Assignor, Assignee, and CalOptima may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. Assignor and CalOptima entered into a Medicare Advantage – Physician Group Services Contract, which was effective January 1, 2023, and subsequently amended twice ("**MA Contract**").

B. Section 12.4 of the MA Contract requires Assignor to obtain CalOptima's prior written consent for any assignment of the MA Contract.

C. Assignor and CalOptima entered into a Medi-Cal Physician – Shared Risk Amended and Restated Contract for Health Care Services, which was effective March 1, 2022, and subsequently amended 14 times ("**Medi-Cal Contract**").

D. Section 14.10 of the Medi-Cal Contract requires Assignor to obtain prior written consent from the California Department of Health Care Services ("**DHCS**") and CalOptima for any assignment of the Medi-Cal Contract.

E. Assignor intends to assign the MA Contract and the Medi-Cal Contract to Assignee ("**Assignments**") such that CalOptima's prior written consent is necessary.

F. The Parties desire to enter into the Agreement to obtain CalOptima's prior written consent to the proposed Assignments.

AGREEMENT

NOW, THEREFORE, in consideration of the above Recitals, which are incorporated into the Agreement by this reference, and the mutual promises and covenants contained in this Agreement, the Parties agree as follows:

1. **CalOptima Consent**. Subject to the terms and conditions contained herein, CalOptima consents to the Assignments under Section 12.4 of the MA Contract and Section 14.10 of the Medi-Cal Contract, as of the Effective Date.

2. **Assignment Obligations**. Assignor and Assignee agree that:

   A. Assignor hereby assigns to Assignee all of Assignor's right, title and interest in and to the MA Contract and Medi-Cal Contract and hereby delegates to Assignee all of its duties and obligations under the MA Contract and Medi-Cal Contract that accrued on or after the Effective Date, subject to the terms, conditions and provisions of this Agreement. Notwithstanding anything to the contrary contained herein, it is specifically understood and agreed that Assignor's assignment to the Assignee of its rights under the MA Contract and Medi-Cal Contract includes the right to receive any and all payments or consideration due thereunder from CalOptima, notwithstanding the fact that the right to

payments or consideration may have accrued, in whole or part, prior to the Effective Date.

B. During the terms of the MA Contract and Medi-Cal Contract, Assignor is prohibited from acting or failing to act in any way that interferes with or prevents Assignee from complying with Assignee's obligations under the MA Contract or the Medi-Cal Contract.

C. To induce CalOptima to consent to the Assignments and in consideration of its so doing, Assignee acknowledges receipt of a copy of the fully executed the MA Contract and Medi-Cal Contract and hereby unconditionally assumes, becomes a party to and agrees to perform all the duties and obligations of Assignor arising under the MA Contract and Medi-Cal Contract, as if Assignee had been an original party thereto, on or after the Effective Date. Notwithstanding anything to the contrary contained herein, Assignee's assumption of Assignor's duties and obligations under the MA Contract and Medi-Cal Contract includes, but is not limited to, any payments or amounts due to CalOptima pursuant to the terms and conditions of the MA Contract and Medi-Cal Contract, notwithstanding the fact that these duties and obligations may have accrued, in whole or in part, prior to the Effective Date.

D. Assignor is in no way released or discharged from the MA Contract and Medi-Cal Contract or its obligations that accrued prior to the Effective Date.

3. **Term**. This Agreement shall become effective on the Assignment Effective Date. The "**Assignment Effective Date**" shall be the date that all necessary regulatory approvals have been issued, including approval by DHCS, and the California Department of Managed Care, and including the subsequent signing of all Parties of the Agreement for an implementation date of January 1, 2024.

4. **Miscellaneous**.

A. Prohibition on Further Assignment. Any further assignment of rights and duties under the MA Contract or the Medi-Cal Contract shall occur only upon the subsequent mutual written agreement of Assignee and CalOptima.

B. Governing Law. This Agreement will be governed by the laws of the State of California.

C. Amendment and Waiver. No amendment, modification, or waiver of any provision of this Agreement shall be effective unless it is in writing and signed by the Parties.

D. Dispute Resolution.

i. *Meet and Confer*. For any dispute arising under or related to this Agreement, the Parties shall use reasonable efforts to meet and confer to 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 any 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 Parties' option, the dispute may proceed immediately to arbitration under Section 4.D.ii.

ii. *Arbitration*. If the Parties are unable to resolve any dispute arising out of or relating to this Agreement under Section 4.D.i, any Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Agreement shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, 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 (2) 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.

iii. *Exclusive Remedy*. With the exception of any dispute that under applicable laws that may not be settled through arbitration, arbitration under Section 4.D.ii is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Agreement that is not resolved through the provider appeals or meet-and-confer processes.

iv. *Waiver*. By agreeing to binding arbitration as set forth in Section 4.D.ii, 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.

E. Counterparts. This Agreement may be executed in two (2) or more counterparts, each of which constitutes an original, but all of which, when taken together, shall constitute but one agreement.

F. Entire Agreement. This Agreement contain the entire understanding between the Parties related to the Assignment and supersedes any prior understandings between the Parties with respect to the subject matter herein.

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Agreement.

TALBERT MEDICAL GROUP, P.C. DBA OPTUM	ORANGE COUNTY HEALTH AUTHORITY DBA CALOPTIMA
By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

MONARCH HEALTH PLAN, INC.
By:
Print Name:
Title: Date:

MEDI-CAL

HMO

RESTATED CONTRACT FOR HEALTH CARE SERVICES

BETWEEN

CALOPTIMA

AND

MONARCH HEALTH PLAN, INC.

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ARTICLES

ATTACHMENTS

F. CERTIFICATION REGARDING LOBBYING – 1 & 2

RESTATED CONTRACT FOR
HEALTH CARE SERVICES
HMO

THIS RESTATED CONTRACT FOR HEALTH CARE SERVICES ("Contract") is effective January 1, 2024 ("Effective Date") by and between Orange County Health Authority, a public agency dba CalOptima Health, ("CalOptima") and Monarch Health Plan, Inc. ("HMO"), with respect to the following facts:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance No. 00-8, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State pursuant to which it is obligated to arrange and pay for the provision of services to Medi-Cal eligible beneficiaries residing in Orange County, California, who receive Covered Services.

C. HMO desires to continue providing or arranging for the provision of Covered Services to Members, as described herein.

D. HMO has a restricted health care service plan license under the California Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code § 1340 *et seq*.), as amended, that permits HMO to provide or arrange for the provision of health care services to assigned Members.

E. CalOptima and HMO desire to effectuate this Contract to restate the terms of the Prior Contract. This Contract shall control and govern the relationship of the parties following the Effective Date with respect to the subject matter contained herein and in the Prior Contract.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
Definitions

1.1 "Administrative Services" means those non-clinical functions that are the responsibility of the HMO and are required to discharge the obligations and meet the requirements set forth in this Contract, in CalOptima Policies and, in Memoranda of Understanding.

1.2 "Adult Expansion Member" means a Member enrolled in aid codes L1 and M1 as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y).

1.3 "Advance Directive" means a written instruction such as under the California Natural Death Act Declarations or durable power of attorney for health care, recognized under State law and relating to the provision of medical care when an individual is incapacitated.

1.4 "Aid Code" means the two-character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.

1.5 "American Indian" means a Member who meets the criteria for an "Indian" as stated in 42 CFR 438.14(a), which includes members in a federally recognized Indian tribe, resides in an urban center and meets one or more of the criteria stated in 42 CFR 438.14(a)(ii), is considered by the Secretary of the Interior to be an Indian for any purpose, or is considered by the Secretary of Health and Human Services to be an Indian for purpose of eligibility for Indian health services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

1.6 "American Indian Health Care Provider" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)."

1.7 "American Indian Health Service Programs" means facilities operated with funds from the Indian Health Service under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible American Indian population with a defined geographic area, per Title 22, Section 55000."

1.8 INTENTIONALLY LEFT BLANK

1.9 "California Children's Services (CCS)" means those services authorized by the CCS Program for the diagnosis and treatment of the CCS Eligible Conditions of a specific Member.

1.10 "California Children's Services (CCS) Eligible Condition(s)", means a physically handicapping condition defined in Title 22 CCR Sections 41515.2 through 41518.9.

1.11 "California Children's Services (CCS) Program" means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (21) years who have CCS Eligible Conditions.

1.12 "CCS Provider" or "CCS-Paneled Provider(s)" means any of the following providers when used to treat Members for a CCS Eligible Conditions:

A. A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106.

B. A licensed acute care hospital approved by the CCS Program.

C. A special care center approved by the CCS Program.

1.13 "CalOptima Board" or "Board" means the CalOptima Board of Directors.

1.14 "CalOptima Direct" or "COD" means a program CalOptima administers for CalOptima beneficiaries not enrolled with a Health Network or HMO.

1.15 "CalOptima Policy(s)" means CalOptima policies and procedures relevant to this Contract, as amended from time to time, at the sole discretion of CalOptima.

1.16 "CalOptima's Regulators" means those government agencies that regulate, oversee, or enforces applicable statutory, regulatory, or contractual requirements relating to the activities and/or obligations of CalOptima, HMO, and Subcontractors under the State Contract, this Contract, and Subcontracts, as applicable, including, without limitation, DHCS, the HHS Office of Inspector General, the Comptroller General of the United States, the Department of Justice (DOJ), DOJ Bureau of Medi-Cal Fraud, Department of Managed Care (DMHC), and other authorized federal or State agencies, or their duly authorized representatives or designees, including DHCS' external quality review organization contractor.

1.17 "Capitation Payment" means the monthly amount paid to the HMO by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by HMO's monthly enrollment based upon Aid Code, age and gender.

1.18 "Capitation Rate" means the rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age and gender.

1.19 "Care Management Services" means:

1.19.1 Providing or approving all Covered Services including health assessments, identification of risks, initiation of intervention and health education deemed Medically Necessary, consultation, referral for consultation and additional health care services;

1.19.2 Coordinating Medically Necessary Covered Services with other Medi- Cal benefits not covered under this Contract;

1.19.3 Maintaining a Medical Record with documentation of referral services and follow-up as medically indicated;

1.19.4 Ordering of therapy, admission to hospitals and coordinated hospital discharge planning that includes necessary post-discharge care;

1.19.5 Authorization of referred services;

1.19.6 Coordinating a Member's care with all external agencies that are required to be involved in addressing the Member's needs as addressed in MOUs and in CalOptima Policies;

1.19.7 Coordinating care for Members transitioning from CalOptima Direct to a Health Network or from one Health Network to another Health Network; and

1.19.8 Targeted services for Members with Special Health Care Needs to support compliance with Federal Medicaid contingencies, including but not limited to: identification of Members with Special Health Care Needs, assessment of Members with Special Health Care Needs, development of treatment plans, and monitoring the progress of adherence to treatment plans for Members with Special Health Care Needs.

1.20 "Child Health and Disability Prevention" or "CHDP" means the California program, defined in the Health and Safety Code Section 12402.5 et seq. that covers certain pediatric preventive services for children eligible for Medi-Cal.

1.21 "Clean Claim" shall have the same meaning as "Complete Claim," as that term is defined in Title 28, CCR Section 1300.71(a)(2).

1.22 INTENTIONALLY LEFT BLANK

1.23 INTENTIONALLY LEFT BLANK

1.24 "Complex Case Management" means an approach to case management that meets differing needs of high and rising-risk Members, including both ongoing chronic care coordination for chronic conditions and interventions for episodic, temporary needs. Complex Case Management includes all services and requirements under Basic PHM. .

1.25 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors and providers comply with applicable law and ethical standards.

1.26 "Comprehensive Perinatal Services Program" or "CPSP" means those services defined in Section 14134.5 of the Welfare and Institutions Code and Title 22, Sections 51179 and 51348 of the California Code of Regulations (CCR). For CalOptima Members, CPSP is incorporated into CalOptima's Perinatal Support Services (PSS).

1.27 "Concentration Languages" means those languages spoken by at least 1,000 Members whose primary language is other than English in a ZIP code, or by at least 1,500 such Members in two contiguous ZIP codes.

1.28 "Contract" means this written instrument between CalOptima and HMO. This Contract shall include, in addition to this document, any Memoranda of Understanding entered into by CalOptima which are binding on HMO, DHCS Medi-Cal Managed Care Policy Division Policy Letters and, Contract Interpretation.

1.29 "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the State Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and, effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, CCS Services (as defined in Subdivision 7 of Division 2 of Title 22 of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program."

1.30 "DHCS" means the State of California Department of Health Care Services.

1.31 "Derivative Aid Code" means an Aid Code, which is a subset of eligible beneficiaries derived from an original covered Aid Code.

1.32 "Disease Management" means a multi-disciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions:

1.32.1 That supports the physician/patient relationship;

1.32.2 Emphasizes prevention of exacerbation and complications utilizing cost-effective evidence based practice guidelines and patient empowerment strategies such as self-management; and

1.32.3 Continuously evaluates clinical humanistic and economic outcomes with the goal of improving health.

1.33 "Early and Periodic Screening, Diagnostic and Treatment" or "EPSDT" means a comprehensive and preventive child health program for individuals under the age of twenty-one (21). EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. In addition, Section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

1.34 "Emergency Medical Condition" means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1.34.1 Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or

1.34.2 Serious impairment to bodily functions; or

1.34.3 Serious dysfunction of any bodily organ or part.

1.35 "Emergency Services" means Covered Services furnished by a qualified Provider, which are needed to evaluate or Stabilize an Emergency Medical Condition that is found to exist using a prudent layperson standard.

1.36 "Encounter" means any unit of Covered Service provided to a Member by Health Network regardless of Health Network reimbursement methodology. These services include any and all services provided to a Member, regardless of the service location or provider, inclusive of out-of-network services, including sub-capitated and delegated Covered Services.

1.37 "Evaluation Services Provider" means a provider of custom wheelchair and seating systems assessment and evaluation services, whether provided in-home or in the provider's facility, designated and contracted to assess and evaluate a Member with Disabilities (MWD)'s needs for custom power wheelchairs and seating systems, or customized modifications to wheelchairs and seating systems.

1.38 "Facility" means any premises:

1.38.1 Owned, leased, used or operated directly or indirectly by or for the HMO for purposes related to this Contract; or

1.38.2 Maintained by a Subcontractor to provide Covered Services pursuant to an agreement with the HMO.

1.39 "Family Planning" means Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes but is not limited to:

1.39.1 Medical and surgical services performed by or under the direct supervision of a licensed physician for the purpose of Family Planning;

1.39.2 Laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or are associated with Family Planning procedures;

1.39.3 Patient visits for the purpose of Family Planning;

1.39.4 Family Planning counseling services provided during a regular patient visit;

1.39.5 IUD and UCD insertions, or any other invasive contraceptive procedures/devices;

1.39.6 Tubal ligations;

1.39.7 Vasectomies;

1.39.8 Contraceptive drugs or devices;

1.39.9 Treatment for complications resulting from previous Family Planning procedures.

1.39.10 Family Planning does not include services for the treatment of infertility or reversal of sterilization.

1.40 "Federally Qualified Health Center" or "FQHC" means an entity as defined in 42 USC Section 1396d(l)(2)(B).

1.41 "Fee-for-Service" or "FFS" means the reimbursement paid to Providers on a non-capitated basis.

1.42 "Foster Care" means an out-of-home placement for a child either on a temporary or permanent basis.

1.43 "Health Education" means any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health.

1.44 "Health Maintenance Organization" or "HMO" means the health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, (commencing with Section 1340 of the California Health and Safety Code) ("Knox-Keene Act") and who is signatory to this Contract.

1.45 "Health Network" means a physician hospital consortium (PHC), physician group under a shared risk contract, or a health care service plan, such as an HMO, as defined in the Knox-Keene Act, and contracted by CalOptima to provide Covered Services to Members.

1.46 "Healthcare Effectiveness Data and Information Set" or "HEDIS" means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

1.47 "HHS" means the United States Department of Health and Human Services.

1.48 "Hospital" means a general acute care hospital licensed under the laws of the State of California and accredited by the Joint Commission, or other Centers for Medicare and Medicaid Services (CMS) deemed accrediting body, and certified for participation under Medicare and Medicaid (Titles XVIII and XIX of the Social Security Act), which is owned or operated by HMO or with which HMO has a Subcontract to provide Covered Services under this Contract.

1.49 "Incontinence Supplies" means Medical Supplies used to manage bowel and/or bladder incontinence.

1.50 "Joint Commission" means the Joint Commission for the Accreditation of Health Care Organizations.

1.51 "Long Term Care Facility" means a facility that is licensed to provide skilled nursing facility services, intermediate care facility services, or sub-acute care services.

1.52 "Management Services Organization" or "MSO" means any organization, firm, company or entity providing Administrative Services on behalf of HMO which impact CalOptima Members.

1.53 "Medi-Cal" is the name for the Medicaid program in the State of California, and "Medicaid" is the program authorized by Title XIX of the Social Security Act and the regulations promulgated thereunder.

1.54 "Medi-Cal Fee Schedule" means the Medi-Cal payment system for reimbursement for physician services in Title 22, CCR, Section 51503.

1.55 Medi-Cal Managed Care All Plan Letter (APL)" and "Policy Letter (PL)" are the means by which DHCS conveys information or interpretation of changes in policy or procedure at the Federal or State levels. APLs and Policy Letters provide instruction to the contractors about changes in Federal or State law and Regulation that affect the way in which they operate or deliver services to Medi-Cal beneficiaries.

1.56 "Medically Necessary" or "Medical Necessity" means reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per title 22, CCR Section 51303(a) and 42 CFR 438.210(a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and Welfare and Institutions Code Section 14132(v).

1.57 "Medical Record" means any record kept or required to be kept by any Provider that documents all the medical services received by the Member, including without limitation inpatient, outpatient, emergency care, referral requests and authorizations.

1.58 "Medical Screening Examination" or "MSE" means an examination within HMO's capability (including ancillary services routinely available) to determine whether or not an Emergency Medical Condition exists.

1.59 "Medical Supplies" means items, which, due to their therapeutic or diagnostic characteristics, are essential to enable Members to effectively complete a physician ordered plan of care, excluding common household items and clothing.

1.60 "Medical Therapy Program (MTP)" means a special program within California Children's Services that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders.

1.61 "Medicare" means the federal health insurance program for: people sixty-five (65) years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called (ESRD) as defined in Title XVIII of the Federal Social Security Act.

1.62 "Member" means a Medi-Cal eligible beneficiary as determined by the County of Orange Department of Social Services, DHCS, or the United States Social Security Administration who is enrolled in the CalOptima Program and the HMO.

1.63 "Member with Special Health Care Needs" means a Member who meets at least one of the following criteria: (i) Medicare eligible; (ii) diagnosed with an emotional or physical disability; (iii) placed in the foster care system; (iv) Regional Center of Orange County (RCOC) program eligible; or (v) CCS Program eligible.

1.64 "Memorandum/Memoranda of Understanding" or "MOU", means agreements between CalOptima and external agencies, which delineates responsibilities for coordinating care to Members, and contracts between CalOptima and the County of Orange that incorporate such agreements, including but not limited to the Coordination and Provision of Public Health Care Services Contract.

1.65 "Minimum Standards" means the minimum participation criteria established by CalOptima that must be satisfied in order for specified categories of Providers to submit claims and/or receive reimbursement from the CalOptima program (including Health Networks and CalOptima Direct) for items and/or services furnished to Members as described in CalOptima Policies.

1.66 "National Committee on Quality Assurance" or "NCQA" means the non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

1.67 "Other Member" means a Medi-Cal beneficiary as determined by the County of Orange Social Services Agency, DHCS, or the United States Social Security Administration who is enrolled by the State in a CalOptima Program but is not enrolled in the HMO.

1.68 "Out-of-Network Provider" means a Provider who is not obligated by a written contract with HMO to provide Covered Services to Members.

1.69 "Outpatient Mental Health Services" means outpatient services that CalOptima will provide for members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies and supplements.

1.70 "Participating Provider" means a Provider who is obligated by a written contract to provide Covered Services to Members on behalf of HMO. All Participating Providers shall be considered Subcontractors.

1.71 "Participation Status" means whether or not a person or entity is or has been suspended or excluded from participation in Federal and/or State health care programs and/or has a felony conviction as specified in CalOptima's Compliance Program and CalOptima Policies.

1.72 "Pediatric Preventive Services" or "PPS" means well child services, which incorporate services covered under the Medi-Cal CHDP Program and the American Academy of Pediatrics Guidelines for Health Supervision.

1.73 "Perinatal Support Services" or "PSS" means obstetrical services enhanced with those perinatal services that are incorporated in CPSP services and perinatal Care Management for pregnant and post-partum Members.

1.74 "Person-Centered Planning" means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-Centered Planning is an integral part of basic and Complex Case Management and discharge planning.

1.75 "PHC" and "PHCs" means a physician-hospital consortium/consortia.

1.76 Not Applicable to this Contract.

1.77 "Physician Incentive Plan" means any compensation arrangement between HMO and a physician or physician group designed to motivate physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Members.

1.78 "Practitioner" means a licensed practitioner, including a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine, Doctor of Chiropractic Medicine (DC), and a Doctor of Dental Surgery (DDS) furnishing Covered Services under medical benefits, as described in CalOptima Policies.

1.79 "Primary Care Physician" or "PCP" means a physician responsible for supervising, coordinating, and providing initial and primary care to patients and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For SPD and CCS Members "Primary Care Physician" or "PCP" shall additionally mean any clinic or Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP, provided that clinic or Specialist Physician is qualified to treat the required range of conditions of the Member.

1.80 "Provider" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution who furnishes health care items or services.

1.81 "Quality Indicators" means measurable variables relating to a specific clinical or health service delivery area, which are reviewed over a period of time to monitor the process or outcome of care delivered in that clinical area.

1.82 "Reinsurance" means coverage provided by CalOptima and any coverage secured by HMO, which limits the amount of risk or liability for the cost of providing Covered Services.

1.83 "Alcohol Misuse Screening and Counseling" or AMSC" (formerly referred to as "Screening, Brief Intervention, and Referral to Treatment" or "SBIRT") means services provided by a Primary Care HMO to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol.

1.84 "Sensitive Services" means those services related to Family Planning, sexually transmitted disease (STD), abortion and Human Immunodeficiency Virus testing.

1.85 Not Applicable to this Contract.

1.86 "SPD Member" means Members in Seniors and Persons with Disabilities Aid Codes

1.87 "Specialist Physician" or "Specialist" means a physician who has completed advanced education and clinical training in a specific area of medicine or surgery.

1.88 "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.

1.89 "Specialty Mental Health Provider" means a person or entity who is licensed, certified or otherwise recognized or authorized under the State law governing the healing arts to provide Specialty Mental Health Services and who meets the standards for participation in the Medi-Cal program. Specialty Mental Health Providers include but are not limited to clinics, hospital outpatient departments, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, hospitals, and licensed mental health professionals, including psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, therapists and registered nurses authorized to provide Specialty Mental Health Services.

1.90 "Specialty Mental Health Services" means:

1.90.1 Rehabilitative services which include mental health services, medication support services, day treatment intensive services, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facility services;

1.90.2 Psychiatric inpatient hospital services;

1.90.3 Targeted Care Management services;

1.90.4 Psychiatrist services;

1.90.5 Psychologist services; and

1.90.6 EPSDT supplemental specialty mental health services.

1.91 "Stabilize" or "Stabilized" means with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, that the woman has delivered the child and the placenta.

1.92 "State" means the State of California.

1.93 "State Contract" means the written agreement between CalOptima and the State pursuant to which CalOptima is obligated to arrange and pay for the provision of Covered Services to certain Medi-Cal beneficiaries in Orange County, California.

1.94 "Subcontract" means a written agreement entered into by the HMO with a Provider who agrees to furnish Covered Services to Members, or any other organization or person who agrees to perform any administrative function or service for HMO specifically related to fulfilling HMO's obligations to CalOptima under the terms of this Contract.

1.95 "Subcontractor" means a Provider or any organization or person who has entered into a Subcontract with HMO. All delegates are Subcontractors, but not all Subcontractors shall be considered delegates. A delegate means an organization or person that subcontracts with HMO to perform any administrative function or service for HMO specifically related to fulfilling HMO's obligations to CalOptima under the terms of this Contract."

1.96 "Sub-delegation" means the process by which HMO expressly grants, by formal written agreement, to another entity the authority to carry out a function that would otherwise be required to be performed by HMO in order to meet its obligations under, and the intent of this Contract.

1.97 "Threshold Languages" means those languages as determined by State requirements per MMCD Policy Letter 99-03, or any update or revision thereof.

1.98 "Urgent Care Services" means Covered Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury for which treatment cannot be delayed.

1.99 "Vaccines for Children" or "VFC" means the federal program, which provides free vaccines for eligible populations. Medi-Cal covered children, ages eighteen (18) years and younger, are eligible for free vaccines under this program.

1.100 "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

1.101 Intentionally left blank.

1.102 Intentionally left blank.

1.103 Intentionally left blank.

1.104 Intentionally left blank.

1.105 ""Basic Population Health Management" or "Basic PHM" means CalOptima's approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's risk tier, at the right time and in the right setting. Basic PHM includes federal requirements for care coordination and comply with all applicable federal and state requirements, and National Committee for Quality Assurance ("NCQA") standards..

1.106 "Enhanced Care Management" or "ECM" means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, high-touch, and person-centered. ECM is a Medi-Cal benefit.

1.107 "ECM Care Team" means a team of staff employed or contracted by the HMO, as an ECM Provider, that provides ECM services to ECM Members.

1.108 "ECM Member" means a CalOptima Medi-Cal Member who meets inclusion criteria for one of the ECM Populations of Focus, authorized to receive ECM services, and assigned to the HMO.

1.109 "ECM Provider" means HMO when providing ECM services to ECM Members pursuant to this Contract.

1.110 "Community Supports means, as set forth in 42 CFR § 438.3(e)(2), services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to the State Plan Covered Services. Community Supports are optional for both CalOptima and the Member and must be approved by DHCS. Effective no sooner than January 1, 2022, CalOptima shall offer the following four (4) selected DHCS-approved Community Supports, as further defined in CalOptima Policy GG.1355: Community Supports: (i) Housing Transition Navigation Services; (ii) Housing Deposits; (iii) Housing Tenancy and Sustaining Services; and (iv) Recuperative Care (Medical Respite).

1.111 "Lead Care Manager" means a Member's designated care manager for ECM, who works for the ECM Provider organization. The Lead Care Manager operates as part of the Member's ECM Care Team and is responsible for coordinating all aspects of ECM and any Community Supports. To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.

1
Obligations of HMO – Financial

2.1 Not Applicable to this Contract.

2.2 INDEMNIFICATION --- Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, or any functions, duties or obligations of such party under this Contract. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

2.3 INSURANCE REQUIREMENTS:

2.3.1 Professional/Medical Malpractice:
Each Participating Provider providing Covered Services to Members shall maintain a Professional Liability (Medical Malpractice) Insurance policy for the specialty or type of service which the Participating Provider provides with minimum limits as follows:

PCP or Specialist Physician:
$1,000,000 per incident/$3,000,000 aggregate

Hospital providing covered services:
$5,000,000 per incident/$5,000,000 aggregate

2.3.2 Commercial General Liability/Commercial Automobile Liability:
HMO 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 HMO's Comprehensive General Liability and Automobile Liability insurance with respect to performance under this Contract.

2.3.3 Workers' Compensation:
HMO and each Participating Provider shall maintain a Workers' Compensation Insurance policy with minimum limits as follows:

Employers' Liability Insurance:
$1,000,000 Bodily Injury by Accident - each accident
$1,000,000 Bodily Injury by Disease - policy limit
$1,000,000 Bodily Injury by Disease - each employee

2.3.4 Managed Care Errors and Omissions:
HMO shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

Managed Care Errors and Omissions:
$5,000,000 each claim/$5,000,000 aggregate

2.3.5 Insurer Ratings: Such insurance shall be provided by an insurer:

(a) rated by A.M. Best with a rating of A V or better; and
(b) "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or
(c) an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7

2.3.6 Captive Risk Retention Group/Self Insured: Where any of the Insurance(s) mentioned in this Section are provided by a Captive Risk Retention Group or self-insured, insurer ratings requirements above may be waived at the sole discretion of CalOptima, but only after review of the Captive Risk Retention Group's or self-insured's audited financial statements.

2.3.7 Cancellation or Material Change: The HMO shall not of its own initiative cause such insurance as addressed in this Article to be cancelled or materially changed during the term of this Contract.

2.3.8 Proof of Insurance: Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance maintained by HMO shall be provided to CalOptima prior to execution of the Contract and annually thereafter. HMO shall provide the Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance maintained by Participating Providers to CalOptima upon request.

2.4 REIMBURSEMENT FOR CERTAIN COVERED SERVICES PROVIDED BY LOCAL HEALTH DEPARTMENT---HMO shall reimburse the Local Health Department (LHD) on a FFS basis, according to the current Medi-Cal Fee Schedule, for certain Covered Services provided to Members, in accordance with CalOptima Policy. This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.5 HMO FINANCIAL RESPONSIBILITY FOR MEDICAL SUPPLY ITEMS --- HMO shall be responsible for authorizing all injectable medications, or medications in an implantable dosage form which shall be reimbursed as set forth in Attachment A, Division of Financial Responsibility.

2.5.1 AS SET FORTH IN ATTACHMENT A, the Division of Financial Responsibilities, HMO shall also be financially responsible for authorizing and paying for Medical Supplies and durable medical equipment with the exception of certain Medical Supplies as set forth in Attachment C.

2.5.2 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.6 SKILLED NURSING FACILITY FINANCIAL RESPONSIBILITY --- HMO shall be financially responsible for Skilled Nursing Facility services daily rate when such services are determined by CalOptima to be in-lieu of acute hospitalization.

2.7 PAYMENTS TO PROVIDERS ---

2.7.1 Capitation Payments - HMO and/or Subcontractors shall distribute monthly capitation payments to capitated Participating Providers within fifteen (15) calendar days following the date on which HMO receives payment from CalOptima.

2.7.2 Claims Turnaround Time - HMO shall reimburse Complete Claims, or any portion of any Complete Claim, for Covered Services, as soon as practical, but no later than

thirty (30) calendar days after receipt of the claim by HMO, unless the claim or portion thereof is reasonably contested by HMO, in which case the claimant shall be notified in writing that the claim is contested or denied within forty-five (45) business days after receipt of the claim by HMO in accordance with CalOptima Policy.

2.7.3 Claims Adjudication – Except as provided in this Section, HMO shall accept and adjudicate claims for Covered Services provided to Members in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to claims processing and payment shall be prohibited.

2.7.4 Dispute Resolution - HMO shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima Policies.

2.7.5 Right Of Appeal - HMO shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to HMO's dispute resolution mechanism involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from HMO's Date of Determination.

2.7.6 CalOptima Payment On Behalf Of HMO

2.7.6.1 If CalOptima receives a copy of an unpaid Complete Claim as part of a Provider grievance that is thirty (30) working days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies.

2.7.6.2 If HMO does not either notify CalOptima that the claim is reasonably contested, as set forth in CalOptima Policies, or pay the Complete Claim within the thirty (30) working day period, CalOptima shall pay the Claim on behalf of HMO, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation payment, in accordance with CalOptima Policy.

2.7.7 Assumption of Delegated Functions.

2.7.7.1 Assumption Of Claims Processing. In the event that HMO fails to timely and accurately reimburse its claims (including the payment of interest and penalties), CalOptima may, at its sole discretion, either assume responsibility from HMO for claims payment, or terminate this Contract as

provided for in Section 13.1 of this Contract. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that HMO has established an approved corrective action plan consistent with Section 1375.4 (b)(4) of the Health and Safety Code.

2.7.7.2 Assumption Of Dispute Resolution. In the event that HMO fails to resolve its Provider disputes in a timely manner, CalOptima may, at its sole discretion, assume responsibility from HMO for dispute resolution, or terminate this Contract as provided for in Section 13.1 of this Contract.

2.7.7.3 Recoupment Of Costs For Assumption Of Claims Processing And/Or Dispute Resolution. CalOptima, at its sole and absolute discretion, may reduce HMO Capitation Rate to recoup additional administrative costs for the assumption of the claims processing and/or dispute resolution responsibilities of HMO, as described in this Section, as well as any amounts, including interest due, on claims unpaid at the assumption of responsibilities by CalOptima.

2.7.8 Quarterly Claims Payment Performance Report.

2.7.8.1 HMO shall submit, in a format specified by CalOptima Policies, a Quarterly Claims Payment Performance Report ("Quarterly Claims Report") to CalOptima within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose HMO's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4 and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the California Code of Regulations.

2.7.8.2 HMO shall ensure that each Quarterly Claims Payment Performance Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the California Code of Regulations, of HMO, stating that the report is true and correct to the best knowledge and belief of the principal officer.

2.7.8.3 HMO's Quarterly Claims Payment Performance Report shall include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to CalOptima.

2.7.9 Forwarding of Misdirected Claims

2.7.9.1 HMO shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are the financial responsibility of the HMO group. HMO will receive misdirected claims per CalOptima Policy.

2.7.9.2 HMO shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that are the financial responsibility of CalOptima within 10 working days of receipt of the claim. CalOptima shall receive these files per CalOptima Policy, and load them into their system to ensure timely claims processing.

2.7.10 FQHCs Payments - If FQHC, HMO shall reimburse the FQHC at a rate comparable to any other Subcontract arrangement for similar services

2.7.11 American Indian Health Service Payments - HMO shall reimburse American Indian Health Care Provider(s) for Covered Services provided to Members who are qualified to receive services from an American Indian Health Care Provider. HMO shall reimburse American Indian Health Care Provider at a rate comparable to any other Subcontract arrangement for similar services.

2.7.12 Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Payments - If there are no CNMs or CNPs in HMO's provider network, HMO shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than one hundred percent (100%) of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy.

2.7.13 Family Planning Provider Payments - HMO shall reimburse non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy. HMO shall reimburse non-contracting family planning providers for services provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

2.7.14 Sexually Transmitted Disease Treatment Payments - HMO shall reimburse local health departments and non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy, for the diagnosis and treatment of a STD episode, as defined in MMCD Policy Letter No. 96-09. HMO may elect to provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to HMO along with billing information.

2.7.15 HIV Testing and Counseling Payments - HMO shall reimburse local health departments and non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy. HMO shall provide reimbursement only if local health departments and non-contracting family planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to HMO.

2.7.16 Information Disclosures To Participating Providers. HMO shall provide to all Participating Providers, initially upon contracting and annually thereafter on or before the Contract anniversary date, and at any time upon request from a Participating

Provider, in an electronic format as defined and detailed in CalOptima Policies, the following:

2.7.16.1 A complete fee schedule.

2.7.16.2 Payment policies and nonstandard coding methodologies used to adjudicate claims.

2.7.17 Provider Payments-

2.7.17.1 HMO shall reimburse contracted Specialist Physician for Covered Services rendered to Members on an aggregate basis, at an amount equal to or greater than one hundred thirty-three percent (133%) of the Medi-Cal fee schedule except for those members specified below.

2.7.17.2 In addition to the requirements in this Contract, effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall compensate CCS paneled physicians and surgeons providing CCS Services to CCS eligible Members at rates that are equal to or exceed the applicable Medi-Cal Program CCS fee-for-service rates, unless the physician or surgeon enters into an agreement on an alternative payment methodology mutually agreed to by HMO and the physician and surgeon.

2.7.17.3 For CCS neonatal intensive care units, HMO shall pay the CCS Provider either the equivalent of Medi-Cal fee-for-service rates, such as the All Patient Refined Diagnosis Related Group (APR-DRG) rates or other established rates, or HMO's negotiated rates, whichever is higher, for up to 12 months after the transition.

2.7.18 DIRECTED PAYMENTS FOR QUALIFYING COVERED SERVICES --- Effective July 1, 2020, CalOptima and HMO shall administer directed payments that are relevant to this Contract in accordance with CalOptima Policy FF.2011, Directed Payments, including, without limitations, directed payments, such as those described in Attachment E-2 and E-3, by HMO to eligible providers rendering qualifying Covered Services, reporting requirements related to directed payments, and reimbursement of directed payments by CalOptima to HMO.

2.7.19 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.8 THIRD PARTY TORT LIABILITY/ESTATE RECOVERY --- HMO 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. HMO shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

2.9 OTHER HEALTH COVERAGE (OHC) --- HMO shall cost avoid or make post-payment recovery for the reasonable value of Covered Services paid by HMO and rendered to Members whenever a Member's OHC covers the same Covered Services, either fully or partially. In no event shall HMO 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. HMO shall coordinate benefits with other programs or entitlements recognizing OHC as primary coverage and Medi-Cal as the payor of last resort. HMO shall not undertake cost avoidance or post-payment recovery except on the basis of OHC reflected in an OHC code reflected in the Medi-Cal eligibility records.

2.9.1 Cost Avoidance - If HMO reimburses a Provider on a Fee-for-Service basis, HMO shall not pay claims for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code without proof that the Provider has first exhausted all benefits of other liable parties. Proof of third party billing is not required before payment for services provided to Members with OHC codes A or N.

2.9.2 Post-Payment Recovery - If HMO reimburses a Provider on a Fee-for-Service basis, HMO shall pay the Provider's claims and then seek to recover the cost of the claim by billing liable third parties for services provided to Members with OHC codes A or N; for services defined by DHCS as prenatal or PPS, or in child support enforcement cases. If HMO does not have sufficient information to determine whether or not OHC is the result of child support enforcement case, then HMO shall follow the procedure above for cost avoidance. If HMO does not reimburse a Provider on a Fee-for-Service basis, then HMO shall pay for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual Covered Services rendered.

2.9.3 HMO shall have written policies implementing these requirements.

2.9.4 HMO shall submit monthly reports to CalOptima identifying OHC in accordance with CalOptima Policies.

2.9.5 HMO shall maintain reports that display claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. Reports shall be made available upon CalOptima request.

2.9.6 HMO shall identify OHC unknown to DHCS within ten (10) days of discovery to CalOptima in accordance with CalOptima Policies.

2.9.7 HMO shall demonstrate to CalOptima that where HMO does not Cost Avoid or perform Post-Payment Recovery that the aggregate cost of this activity exceeds the total revenues HMO projects it would receive from such activity.

2.9.8 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under

this Contract prior to termination. This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.10 MEDICAL LOSS RATIO --- HMO shall maintain a minimum acceptable medical loss ratio as defined by CalOptima Policies of eighty-five percent (85%).

2.11 FINANCIAL VIABILITY STANDARDS AND REPORTING --- HMO shall maintain a cash-to-claims ratio of no less than .75 at all times during this Contract. HMO shall substantiate compliance with this requirement by submitting all applicable reports to the Department of Managed Health Care.

2.12 COOPERATION WITH DMHC --- HMO shall fully cooperate and comply with the Department of Managed Health Care's review and audit process, and permit DMHC to obtain and evaluate supplemental financial information related to HMO. HMO shall also fully cooperate and participate in DMHC's Corrective Action Plan (CAP) process.

2.13 Not Applicable to this Contract.

ARTICLE 3
Obligations of HMO - Administrative

3.1 STATUTORY REQUIREMENTS --- HMO shall retain at all times during the period of this Contract a valid restricted Knox-Keene license issued by the California Department of Managed Health Care (DMHC).

3.2 EQUAL OPPORTUNITY

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

disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

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

3.2.3 HMO and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of HMO and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

3.2.4 HMO and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

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

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

3.2.7 HMO and its Subcontractors will include the provisions of Sections 3.2.1 through 3.2.7 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. HMO 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 in the event HMO and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, HMO and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

3.3 MARKETING GUIDELINES --- HMO shall comply with the marketing guidelines set forth in CalOptima Policies.

3.4 CALOPTIMA LOGO --- HMO shall not display the CalOptima logo on any of HMO's written communication to Members without prior written approval by CalOptima.

3.5 MEMBER INQUIRIES AND CALLS --- HMO shall establish and maintain a call center for receiving and responding to Member inquiries and calls. HMO's call center shall meet requirements established by CalOptima Policies. HMO shall equip and furnish call center including but not limited to appropriate telephone equipment and systems, so as to assure HMO shall supply reports of call center performance as required by CalOptima Policies.

3.6 WRITTEN MATERIALS --- Except as otherwise provided in this Contract, HMO shall ensure that all written Member information provided by HMO to Members is provided at a sixth grade reading level, or as determined appropriate through the CalOptima group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan covered services, processes and ensure the Member's ability to make informed health decisions. Written Member informing materials, shall be translated into the identified Threshold and Concentration Languages. Written Member informing materials shall be provided in alternative formats (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested. HMO shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.

3.7 COMPLAINTS AND GRIEVANCES ---

3.7.1 Member Grievance Procedures - Members or Members' authorized representative may file grievances about any aspect of service delivery provided or arranged by HMO. HMO shall implement and comply with CalOptima Policies relating to

Member grievances. HMO shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

3.7.2 Provider Grievance Procedures - Providers may file grievances about any aspect of service delivery provided or arranged by HMO. HMO shall implement and comply with CalOptima Policies relating to Provider grievances.

3.8 SUB-DELEGATION AND SUBCONTRACTING OF ADMINISTRATIVE SERVICES. Except as otherwise limited by the State Contract, this Contract and/or CalOptima Policies and subject to CalOptima's prior written approval, HMO may sub-delegate to an MSO, medical group, and/or IPA administrative functions required of HMO but shall not absolve HMO of oversight responsibilities. All sub-delegation must be approved by CalOptima. HMO shall obtain approval of sub-delegation from CalOptima pursuant to the process detailed in CalOptima Policies. HMO's Sub-delegation to another entity does not alter HMO's ultimate obligation and responsibilities set forth in this Contract. HMO may give a sub- delegate the authority to act on behalf of HMO; but HMO retains oversight and accountability for the sub-delegated function. Accountability means that HMO cannot abdicate responsibility for the function being performed according to the requirements of this Contract, HMO's standards and those established by this Contract and CalOptima Policies. HMO is accountable for all functions performed in its purview whether by HMO, by any sub-delegate or by any sub-sub-delegate. If HMO chooses to sub-delegate a function, HMO must demonstrate that it has not compromised its ability to evaluate structures and processes and to achieve required performance across its Membership and provider network. At a minimum, HMO shall provide CalOptima no later than one hundred twenty (120) days prior to the proposed effective date of the sub-delegation, with written evidence of the sub-delegation including:

3.8.1 A copy of the written agreement which meets the requirements of this Section and which describes the relationship between the HMO and the sub-delegate entity including the following information:

3.8.1.1 The sub-delegated functions;

3.8.1.2 The responsibilities of the HMO and the sub-delegate entity;

3.8.1.3 The frequency of the sub-delegate entity's performance;

3.8.1.4 The process by which the HMO evaluates the sub-delegate entity's performance; and

3.8.1.5 The HMO's remedies if the sub-delegate entity fails to fulfill its obligations including revocation of the sub-delegation.

3.8.2 A description of the HMO's process by which the sub-delegate entity was evaluated and selected to perform the sub-delegated functions, including the entity's score on a selection tool (if any).

3.8.3 A record of the HMO's ongoing oversight process, as requested by CalOptima including:

3.8.3.1 The HMO's annual evaluation of whether the entity is performing the sub-delegated functions in accordance with this Contract and NCQA standards;

3.8.3.2 The HMO's review of the sub-delegate entity's regular reports; and

3.8.3.3 Reports and data required to be submitted to CalOptima.

3.8.4 HMO shall terminate as soon as practical to meet the health care needs of Members, upon receiving written notification from CalOptima, any sub-delegation that fails to meet standards established by CalOptima and/or any of the requirements in this Contract or in CalOptima Policies.

3.8.5 HMO shall report to CalOptima in accordance with all requirements established in this Contract and in CalOptima Policies, data and information that includes and encompasses all of HMO's Members, including those receiving services from a sub-delegate of HMO.

3.8.6 HMO shall oversee and monitor its sub-delegates, and audit sub-delegates no less than once in any twelve- (12) month period. HMO shall establish standards and performance requirements for sub-delegate function(s) and requirements for sub-delegates shall require sub-delegate to meet or exceed all requirements of HMO in this Contract and in CalOptima Policies. HMO may be exempt from oversight, monitoring and auditing of sub-delegate if the sub-delegate is:

3.8.6.1 Contracted directly with CalOptima as a Health Network, or as a participant in a Health Network (i.e. a Shared Risk Group, PHC Physician Group, or PHC Hospital), or

3.8.6.2 NCQA accredited or certified for the function(s) sub-delegated by HMO to sub-delegate.

3.8.7 Sub-delegates failing to meet performance requirements shall be placed on a Corrective Action Plan (CAP). The CAP shall detail sub-delegate's deficiencies; list specific steps, tasks and activities to bring sub-delegate into compliance; and a timeline for completion of corrective action and to achieve compliance with performance requirements. HMO shall notify CalOptima of any sub-delegate providing services to CalOptima Members that is on a CAP. HMO shall provide CalOptima a copy of the CAP if requested.

3.9 SUBCONTRACTS --- HMO may Subcontract for certain functions covered by this Contract subject to the requirements of this Contract. HMO is required to ensure that all Subcontracts are in writing and include any general requirements of this Contract and all provisions required by this Contract to be incorporated into Subcontracts. HMO is required to inform CalOptima of the name and business addresses of all Subcontractors and notify CalOptima of any changes in Subcontractors within thirty (30) days of execution or change of Subcontract. HMO shall have policies and procedures addressing Subcontracts with any offshore individual or entity

that receives, processes, transfers, handles, stores, or accesses CalOptima Member Protected Health Information (PHI) ("Offshore Subcontracts"), including policies that address security of such PHI and CMS requirements for reporting information about Offshore Subcontracts. HMO shall annually complete the CalOptima Offshore Attestation and make its Offshore Subcontract policies and list of such Offshore Subcontracts available to CalOptima upon request, including for audits by CalOptima and/or CalOptima's Regulators. Additionally, HMO shall require all Subcontracts contain the following:

3.9.1 An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for an audit, inspection, evaluation, examination or copying in accordance with Sections 3.18 to 3.20 of this Contract;

3.9.2 An agreement to maintain such books and records in accordance with any record requirements in this Contract and CalOptima Policies, and for the establishment and maintenance of and access to Medical and Administrative Records as set forth in Section 3.17 and 3.22 of this Contract;

3.9.3 Requirements for cultural and linguistic sensitivity and provision of interpreter services to be provided as set forth in Sections 3.33 and 3.34 of this Contract;

3.9.4 An agreement to submit provider data, encounter data, and reports relating to the Subcontract in accordance with Sections 7.2, 7.10, and 7.11 of this Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Sections 3.21 and 3.21.1 of this Contract;

3.9.5 An agreement to maintain and make available to DHCS, CalOptima, and/or HMO, upon request, all sub-subcontracts relating to the Subcontract, and to ensure that all sub-subcontracts are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 3.45 of this Contract;

3.9.6 An agreement requiring compliance with any MOU entered into by CalOptima, which are binding on the HMO;

3.9.7 An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in a non-discriminatory manner;

3.9.8 An agreement to comply with all provisions of this Contract with respect to providing Emergency Services and State Contract (Exhibit A, Attachment 8, Provision 12) for those Subcontractors at risk for non-contracting Emergency Services;

3.9.9 An agreement that Subcontractors shall notify HMO of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent;

3.9.10 An agreement to comply with (a) CalOptima's Compliance Program including, without limitation, CalOptima Policies; (b) any DHCS Medi-Cal Provider Bulletins and Manuals; (c) all applicable requirements of the DHCS Medi-Cal Managed Care

Program, including, but not limited to, the Medi-Cal Managed Care Division Policy Letters and All Plan Letters; and (d) all applicable requirements specified in the State Contract and subsequent amendments, and federal and State laws and regulations;

3.9.11 An agreement that Participating Providers comply with the CalOptima Approved Drug List.

3.9.12 An agreement requiring Subcontractors to sign a Declaration of Confidentiality, which shall be signed and filed with DHCS prior to the Subcontractors being allowed access to computer files or any other data or files, including identification of individual Members;

3.9.13 An agreement to hold harmless the State, Members and CalOptima, in the event HMO cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.1.9 of this Contract;

3.9.14 An agreement to assist and cooperate with HMO and/or CalOptima in the transfer of care of a Member in the event of termination of the State Contract, Contract, or Subcontract, for any reason in accordance with Sections 8.2 and 8.2.1 of this Contract;

3.9.15 In the event that HMO implements and maintains a Physician Incentive Plan, it shall ensure that: (A) no specific payment is made directly or indirectly under the incentive plan to a physician or physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member; and (B) the stop-loss protection (reinsurance), beneficiary survey, and disclosure requirements of 42 CFR § 417.479, 42 CFR § 422.208, and 42 CFR § 422.210 are met by HMO.

3.9.16 Subcontractor shall comply with all monitoring provisions of this Contract and the State Contract and any monitoring requests by CalOptima and DHCS.

3.9.17 Services to be provided by the Subcontractor, term of the Subcontract (beginning and end dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor;

3.9.18 Subcontract or its amendments are subject to DHCS approval as provided in the State Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract;

3.9.19 An agreement (a) that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 14.10 of this Contract, and (b) to notify DHCS in a manner provided in Section 8.4 of the Contract in the event the Subcontract is amended or terminated;

3.9.20 An agreement to participate and cooperate in quality improvement systems as set forth in Section 6.4 of the Contract, and if HMO delegates quality improvement activities to the Subcontractor, the Subcontract must include the requirements set forth in the State Contract (Exhibit A, Attachment 4, Provision 6), and Sections 3.8 and 6.4 of the

Contract, including the Delegation Acknowledgement and Acceptance Agreement ("Delegation Agreement");

3.9.21 An agreement to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies, in accordance with Section 3.46 of this Contract, in instances where DHCS, CalOptima, and/or HMO determines that the Subcontractor has not performed satisfactorily;

3.9.22 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Sections 6.11.9 and 14.12 of the Contract;

3.9.23 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 10.10 of this Contract;

3.9.24 An agreement by the HMO to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 13.12 of the Contract; and

3.9.25 An agreement that Participating Providers are entitled to the protections of the Health Care Provider's Bill of Rights, California Health and Safety Code section 1375.7, in the administration of the Subcontract relative to the Medi-Cal program; and

3.9.26 Subcontractor's agreement to provide HMO with the disclosure statement set forth in 22 CCR Section 51000.35, prior to commencing services under the Subcontract, which shall be provided to CalOptima upon request.

3.10 HMO ORGANIZATION AND OPERATIONS STRUCTURE --- HMO shall comply with the organization and operations structure requirements of applicable laws and regulations. Without limiting the foregoing, HOM shall maintain a full time physician as Medical Director/Chief Medical Officer (CMO) whose responsibilities shall include, but not limited to, the following:

3.10.1 Ensuring that medical decision are: (i) rendered by qualified medical personnel, and (ii) are not unduly influenced by fiscal or administrative management considerations.

3.10.2 Ensuring that the medical care provided meets the standards for acceptable medical care.

3.10.3 Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.

3.10.4 Developing and implementing medical policy.

3.10.5 Resolving grievances related to medical quality of care.

3.10.6 Direct involvement in the implementation of Quality Improvement activities.

3.10.7 Actively participate in the functioning of the grievance and appeal procedures.

3.11 ENROLLMENT --- HMO shall accept as Members all persons indicated by CalOptima's information system and through regular transmission from CalOptima to HMO.

3.12 PCP ASSIGNMENT --- HMO shall assign Members who have been automatically assigned to HMO by CalOptima to a PCP within seven (7) days of the Member's assignment to HMO.

3.13 REQUIRED ENROLLMENT INFORMATION AND NOTICE --- HMO shall mail to a Member or Member's head of household a notice of enrollment and a HMO Member handbook or CalOptima approved supplement to the CalOptima Member handbook no later than seven (7) calendar days after receipt of notification that a Member has been enrolled with HMO. All member handbooks and supplements prepared by HMO shall be submitted to CalOptima for approval prior to printing. HMO shall not distribute to Members materials not approved by CalOptima. All materials shall be professionally produced and presented.

3.13.1 Should HMO choose to utilize the CalOptima Member handbook, HMO-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 HMOs' CalOptima Members. CalOptima shall provide HMO with a template for the supplement to the CalOptima member handbook.

3.13.2 If HMO chooses to produce and use a Member handbook other than the CalOptima Member handbook, in addition to the requirements in this Contract, HMO's Member handbook shall contain all information included in the CalOptima Member handbook and HMO-specific information on each topic as defined by CalOptima Policies.

3.13.3 HMO shall provide Members with periodic updates, as needed, explaining changes in the above policies or services. CalOptima shall approve all updates prior to printing. HMO shall also provide one (1) copy of its enrollment information including its HMO Member handbook or supplement to every Participating Provider.

3.14 SPECIAL DISENROLLMENT --- HMO may request and CalOptima may approve according to CalOptima Policies disenrollment for specific Members.

3.15 VOLUNTARY DISENROLLMENT --- All Members have the right to disenroll from a Health Network. CalOptima shall process Member disenrollment in accordance with CalOptima Policies.

3.16 ADDITIONAL SERVICES --- HMO shall not solicit enrollment through the offer of any compensation, reward, or benefit to the Member except for additional health-related services, which have been approved by CalOptima.

3.17 MEDICAL AND ADMINISTRATIVE RECORDS --- HMO shall require that all Participating Providers and Subcontractors establish and maintain for each Member who has obtained Covered Services from a Participating Provider or Subcontractor a legible Medical Record. Such Medical Record shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Participating Provider or Subcontractor. Such Medical Record shall be in such a form as to allow trained health professionals, other than the Participating Provider or Subcontractor, to readily determine the nature and extent of the Member's medical problem and the services provided and permit peer

review of the services provided. The Medical Record shall be kept in a detail consistent with good medical and professional practice in accordance with 22 CCR Section 53284, and which permits effective professional review and facilitates a system of follow-up treatment. All Medical Records shall meet the requirements of State Contract and applicable laws and regulations, including, but not limited to, 28 CCR Section 1300.80(b)(4) and 42 USC Section 1936a(w). Such records shall be available to health care providers at each encounter, in accordance with 28 CCR Section 1300.67.1(c). HMO shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each Participating Provider or Subcontractor site.

3.17.1 HMO and CalOptima agree to maintain the confidentiality of the Member's Medi-Cal status and information contained in the Member's Medical Records in accordance with federal and State law. HMO shall require that all Participating Providers and Subcontractors maintain the confidentiality of a Member's Medi-Cal status and information contained in a Member's Medical Records in accordance with federal and State Law.

3.17.2 Medical records under this Section shall reflect all aspects of patient care, including ancillary services, in accordance with CalOptima Policies, and shall, at a minimum, contain:

3.17.2.1 Member identification on each page; personal/biographical data in the record.

3.17.2.2 Initial Health Assessment within 120 days of enrollment.

3.17.2.3 Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.

3.17.2.4 All entries dated and author identified; for member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the diagnosis and treatment plan.

3.17.2.5 The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.

3.17.2.6 Allergies and adverse reactions are prominently noted in the record.

3.17.2.7 All informed consent documentation, including the human sterilization consent procedures required by Sections 51305.1 through 51305.6 of Title 22 of the California Code of Regulations, if applicable.

3.17.2.8 Reports of emergency care provided (directly by a contracted provider or through a non-contracted emergency room) and the hospital discharge summaries for all hospital admissions.

3.17.2.9 Consultations, referrals, specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.

3.17.2.10 For medical records of adults, documentation of whether the individual has been informed and has executed an advanced directive, such as a Durable Power of Attorney for Health Care.

3.17.2.11 Health education behavioral assessment and referrals to health education services.

3.17.3 It is understood that all Participating Provider's and Subcontractors' books and records pertaining to goods and services furnished under this Contract:

3.17.3.1 Shall be made available for inspection or copying at HMO's, Participating Providers' and/or Subcontractors' expense by CalOptima or authorized representative of State or federal government at all reasonable times at the HMO's, Participating Providers' or Subcontractors' place of business or at such other mutually agreeable location in California; and

3.17.3.2 Shall be maintained in accordance with the general standards applicable to such book or record keeping.

3.18 RECORDS RETENTION --- HMO and Subcontractors shall retain, preserve and make available upon request all records relating to the performance of its obligations under the Contract, including claim forms and encounter data, for a period of not less than ten (10) years from the final date of the contract between CalOptima and DHCS, or the date of completion of any audit, whichever is later, unless a longer period is required by law, with the exception in which HMO or Subcontractor has been duly notified that DHCS, DHHS, the Department of Managed Health Care, the Department of Justice or Comptroller General of the United States, or their duly authorized representative have commenced an audit or investigation of the Contract or any Subcontract, until such time as the matter under audit or investigation has been resolved, whichever is later. Records involving matters that are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Pediatric records for un-emancipated minor Members shall be maintained until the latter of the full retention period under this Section, or at least one (1) year after the Member has reached eighteen (18) years of age. Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system.

3.18.1 HMO shall, upon request of CalOptima, transfer copies of such records to CalOptima's possession. No records shall be destroyed or otherwise disposed of prior to the retention period stated in Section 3.18without the prior written consent of CalOptima. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

3.19 ACCESS TO PREMISES --- CalOptima and the State, through any authorized representatives, have the right at all reasonable times to monitor, inspect or otherwise evaluate the work performed or being performed hereunder, including subcontract supported activities and the premises in which it is being performed. If any monitoring, inspection or evaluation is made of the premises of HMO or Subcontractor, HMO shall provide, and shall require

Subcontractors to provide, all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All monitoring, inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

3.19.1 Through the end of the records retention period specified in Section 3.18, HMO shall make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 21: (a) by CalOptima and/or CalOptima's Regulators; (b) at all reasonable times at the HMO's place of business or such other mutually agreeable location in California; (c) in a form maintained in accordance with the general standards applicable to such book or record keeping; and (d) including all encounter data for a period of at least ten (10) years.

3.19.2 Through the end of the records retention period specified in 3.18, HMO shall allow CalOptima and/or CalOptima's Regulators to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, Facilities, contracts, computers, or other electronic systems maintained by HMO and Subcontractors pertaining to these services at any time pursuant to 42 CFR section 438.3(h). Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, Medical Records, prescription files, laboratory results, Subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 3.18, HMO shall furnish any record, or copy of it, to CalOptima, DHCS or any other CalOptima's Regulators, at HMO's sole expense. CalOptima and DHCS may conduct unannounced validation reviews of the HMO's Primary Care or other service sites, selected at DHCS' discretion, to verify compliance of these sites with State and Federal regulations and Contract requirements. CalOptima and authorized State and Federal agencies will have the right to monitor all aspects of HMO's operation for compliance with the provisions of this Contract and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of HMO, Subcontractor, and provider facilities, management systems and procedures, and books and records as CalOptima or DHCS deems appropriate, at any time pursuant to 42 CFR section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, CalOptima, the State and their authorized representatives and designees will have the right to premises access, with or without notice to HMO. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by CalOptima and authorized State agencies will have access to all security areas and HMO will provide, and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to the CalOptima or State representative(s) in the performance of their duties. Access will

be undertaken in such a manner as to not unduly delay the work of the HMO and/or the Subcontractor(s).

3.20 ACCESS TO AND AUDIT OF CONTRACT RECORDS --- Throughout the duration of the Contract and the retention period as specified in Section 3.18, HMO and Subcontractor shall provide duly authorized representatives of the State or federal government or CalOptima access to all records and material relating to HMO's provision of and reimbursement for activities contemplated under the Contract, and to HMO's financial condition and ability to bear risk under applicable state and federal laws. Such access shall include the right to inspect, audit and have available all such records and material and to verify reports furnished in compliance with the provisions of the Contract. All information so obtained shall be accorded confidential treatment as provided under applicable law. CalOptima employees shall sign HMO's statement of confidentiality prior to being admitted access to HMO's premises. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the HMO at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the HMO from participation in the Medi-Cal program; seek recovery of payments made to the HMO; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract due to fraud.

3.21 RECORDS RELATED TO RECOVERY FOR LITIGATION --- Upon request by CalOptima, HMO 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 HMO's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If HMO asserts that any requested documents are covered by a privilege, HMO shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. HMO acknowledges that time may be of the essence in responding to such request. HMO shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by HMO or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

3.21.1 HMO further agrees to timely gather, preserve, and provide to DHCS any records in the HMO's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

3.22 MEMBER REQUEST FOR MEDICAL RECORDS --- HMO and Subcontractor shall furnish a copy of a Member's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Participating Provider or an Out of Network Provider, at no cost to CalOptima or to the Member when:

3.22.1 Such a transfer of records facilitates the continuity of that Member's care; or

3.22.2 The Member is transferring from one Provider to another for treatment; or

3.22.3 A Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

3.23 DISCLOSURE OF OWNERSHIP --- As identified in Attachment B, HMO shall keep CalOptima informed as to the names of the officers and owners of HMO holding more than five percent (5%) of the stock issued by HMO, and major creditors holding more than five percent (5%) of the debt of the HMO. HMO shall notify CalOptima whenever changes occur to the information provided therein.

3.23.1 If the provider is of a provider type that is not eligible to be Medi-Cal enrolled through DHCS, HMO shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations, for its Providers.

3.24 FRAUD AND ABUSE REPORTING --- HMO shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Participating Providers, Out of Network Providers, Members, or HMO's employees, within five (5) working days of the date when HMO first becomes aware of or is on notice of such activity.

3.24.1 HMO shall notify CalOptima, and CalOptima shall notify DHCS prior to HMO conducting any investigations. HMO shall conduct an investigation after notification has been given.

3.24.2 HMO shall provide to CalOptima and/or CalOptima's regulators, upon request, written policies and procedures for identifying, investigating and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program.

3.24.3 HMO shall report all investigation results to CalOptima within two (2) working days of conclusion of any fraud and/or abuse investigation.

3.25 COMPLIANCE WITH APPLICABLE LAW --- HMO shall observe and comply with all federal and State law in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects the HMO's performance under this Contract. This Contract shall be governed by and construed in accordance with applicable federal and State law and with the terms and obligations under the State Contract.

3.26 HMO COMPLIANCE PROGRAM --- HMO shall develop and implement a comprehensive and effective Compliance Program, including a Compliance Plan. Such Compliance Program shall include, but is not limited to, the implementation of the Office of Inspector General's (OIG) 7 Elements of an Effective Compliance Program: Standards & Procedures, Oversight, Education & Training, Auditing & Monitoring, Reporting, Enforcement and Discipline, and Response & Prevention. Compliance Programs shall be evaluated by the HMO annually to ensure that it remains effective. HMO shall make the Plan and related documents available to CalOptima upon request.

3.27 COMPLIANCE WITH CALOPTIMA'S COMPLIANCE PROGRAM --- HMO and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("HMO's Agents") shall comply with the requirements of CalOptima's Compliance Program, as may be amended from time to time, including the Code of Conduct and Compliance Plan. CalOptima shall make its Compliance Manual and Code of Conduct available to HMO and HMO shall make them available to HMO's Agents.

3.28 COMPLIANCE WITH STATE AND FEDERAL PROGRAMS --- HMO shall comply with requirements established by State and/or federal programs relating to its performance under this Contract. HMO's compliance shall include, but not be limited to, applicable requirements of the DHCS Medi-Cal Managed Care Program, provisions of the State Contract requirements for CalOptima to maintain CMS waiver, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division Policy Letters and All Plan Letters, as well as applicable requirements specified in the State Contract and subsequent amendments, and State and federal laws and regulations.

3.29 COMPLIANCE WITH POLICIES AND PROCEDURES --- HMO 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. HMO acknowledges and agrees that it shall implement CalOptima Policies applicable to its obligations under this Contract.

3.30 COMPLIANCE WITH MEMORANDUM/MEMORANDA OF UNDERSTANDING (MOU(s)) --- HMO agrees to comply with and be bound by any and all applicable MOUs entered into by CalOptima. HMO agrees to require Subcontractors to comply with applicable requirements of such MOUs.

3.31 COMPLIANCE WITH PARTICIPATION STATUS REQUIREMENTS ---HMO shall have policies and procedures to verify the Participation Status of HMO's Agents. HMO shall refer to the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (LEIE) (http://oig.hhs.gov), as well as the GSA Excluded Parties Lists Systems (EPLS) in the SAM System (https://www.sam.gov). In addition, HMO warrants and agrees as follows:

3.31.1 HMO and HMO's Agents shall meet CalOptima's Participation Status requirements during the term of this Contract.

3.31.2 HMO shall immediately disclose to CalOptima any pending investigation involving, or any determination of, suspension, exclusion or debarment by HMO or HMO's Agents occurring and/or discovered during the term of this Contract.

3.31.3 HMO shall take immediate action to remove any HMO Agent that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to Members and shall immediately notify CalOptima.

3.31.4 HMO shall include the obligations of this Section in its Subcontracts.

3.32 NON-DISCRIMINATION --- During the performance of this Contract, neither HMO nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), medical condition (including cancer), mental disability, marital status, age (over 40), or the use of family and medical care leave and pregnancy disability leave. HMO and Subcontractors shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. HMO and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, and et seq.) and the applicable regulations promulgated thereunder (CCR, Title 2, Section 7285.0, and et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. HMO 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. HMO shall include the non-discrimination and compliance provisions of this Section in all Subcontracts to perform work under this Contract.

3.32.1 HMO and all Subcontractors shall abide by Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the HMO nor Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons of groups defined in Penal Code 422.56 in accordance with Title VI of the Civil Rights Act of 1964, 42 USC, Section 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

3.32.2 For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a Facility; (ii) providing to a Member any Covered Service which is different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating a Member differently from others similarly

situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions which individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

3.32.3 HMO shall take affirmative action to ensure that all Members are provided Covered Services without unlawful discrimination, except where medically indicated. For the purposes of this Section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

3.32.4 HMO shall act upon all complaints alleging discrimination against Members in accordance, with CalOptima's Member Complaint Policy and shall forward copies of all such grievances to CalOptima, attention Grievance & Appeals Resolution Services, within five (5) days of receipt of same.

3.32.5 HMO shall require all downstream providers to cooperate with CalOptima's Member Complaint Policy and time requirements to appeals within designated time frames.

3.33 LINGUISTIC AND CULTURAL SENSITIVITY --- CalOptima will provide cultural competency, sensitivity, and diversity training. HMO shall comply with all the following requirements related to the provision of linguistic and culturally sensitive services in accordance with this Contract and CalOptima Policies.

3.33.1 HMO 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. HMO shall provide cultural competency, sensitivity, or diversity training for staff, providers and Subcontractors at key points of contact. HMO 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. HMO shall also, as appropriate, refer Members to culturally-appropriate community services programs.

3.33.2 Pursuant to CalOptima Policies, HMO shall provide translation of written member informing materials in the Threshold and Concentration Languages. HMO shall comply with the language assistance standards developed pursuant to California Health and Safety Code section 1367.04. Written member informing materials to be translated include, but are not limited to: 1) signage; 2) Evidence of Coverage and/or Member Services Guide; 3) disclosure forms; 4) provider listing or directories; 5) marketing materials; 6) form letters; 7) plan-generated preventive health reminders; 8) member surveys; and 9) newsletters. If a Member requests materials in a language not meeting the numeric Thresholds or Concentration Standards, HMO shall provide oral translation of the written materials utilizing bilingual staff or a telephonic interpreter service. HMO shall also make materials available to Members in alternate

formats (e.g. Braille, audio, large print) upon request of the Member. HMO shall be responsible for ensuring the quality of translated materials at no cost to CalOptima or Member.

3.34 PROVISION OF INTERPRETERS --- HMO 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 HMO 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. HMO shall have in place telephonic and face-to-face interpreter services and American Sign Language interpreter services contracts. HMO shall provide twenty-four (24) hour access to interpreter services for all Members, and shall implement policies and procedures to ensure compliance by subcontracted providers with these standards. Such access shall include access for users of Telecommunication Devices for the Deaf (TDD) or Telecommunications Relay Services (711 system). Upon a Member or Participating Provider request for interpreter services in a specific situation where care is needed, HMO 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, HMO must ensure provision of telephonic interpreter services or interpretation through bilingual staff members. HMO 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. HMO shall not require or suggest that a Member to use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Member; (ii) will not compromise the effectiveness of service; (iii) will not violate Member's confidentiality; and (iv) the Member is advised that an interpreter is available at no cost to the Member. HMO shall ensure the linguistic capabilities and proficiency of individuals providing interpreter services.

3.35 MEMBER RIGHTS --- HMO shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policy, are fully respected and observed. HMO shall make Member Rights available to Member.

3.36 PARTICIPATING PROVIDER-MEMBER COMMUNICATION --- HMO shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from communicating with Members, and shall encourage its health care professionals to freely communicate the following to patients, regardless of benefit coverage:

3.36.1 The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

3.36.2 Any information the Member needs in order to decide among all relevant treatment options.

3.36.3 The risks, benefits, and consequences of treatment or non-treatment.

3.36.4 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3.37 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE

3.37.1 HMO and CalOptima shall make any and all efforts and take any and all actions necessary to comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future, within a reasonable time prior to the effective date of such requirements, but not later than the time permitted by the applicable HIPAA requirement after date of finalization.

3.37.2 HMO shall comply with HIPAA requirements as currently established in CalOptima Policies. HMO shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

3.37.3 The parties agree to comply with the terms and conditions of the Health Network HIPAA Business Associates Agreement.

3.38 CONFIDENTIALITY OF INFORMATION

3.38.1 HMO and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract or persons whose names or identifying information become available or are disclosed to HMO, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. HMO and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out HMO's obligations under this Contract. HMO and its employees, agents, or Subcontractors shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. HMO shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, Protected Health Information (PHI): names, geographical subdivisions smaller than a state, all elements of dates (except for year), phone and fax numbers, e-mail address, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, license numbers, vehicle identifiers, device identifiers, web Universal Resource Locators (URLs), internet protocol address numbers, biometric identifiers, including finger and voice prints, full face photograph images, any other unique identifying number, characteristic or code.

3.38.2 Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose

of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by HMO from unauthorized disclosure. HMO may release Medical Records in accordance with applicable law pertaining to the release of this type of information. HMO is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by HMO or its Subcontractors, HMO:

3.38.2.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

3.38.2.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

3.38.2.3 will not disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

3.38.2.4 will, at the termination of this Contract, return all such information to DHCS or maintain such information according to written procedures sent to the HMO by DHCS for this purpose.

3.39 REINSURANCE ---CalOptima arranges for the provision of reinsurance, as described more fully in CalOptima Policies. CCS Eligible Members with CCS Eligible Conditions shall be excluded from CalOptima's provision of reinsurance. HMO may, at its option and sole expense purchase supplemental Reinsurance from a source other than CalOptima. Additionally, HMO shall:

3.39.1 Identify a Reinsurance coordinator who shall serve as CalOptima's contact for all Reinsurance issues; and

3.39.2 Comply with CalOptima Policies for monitoring and monthly reporting of all Reinsurance claims activities.

3.39.3 In lieu of CalOptima-provided reinsurance, services for CCS Members shall be subject to interim reimbursement for catastrophic cases and retrospective risk corridors, as provided in Attachment E.

3.40 CLAIMS MANAGEMENT AND ADMINISTRATION --- HMO shall have a process for claims management and administration. HMO 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. HMO shall date stamp all Provider claims upon receipt. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

3.41 TWENTY-FOUR (24) HOUR TELEPHONE COVERAGE--- HMO shall have one (1) California State wide toll-free telephone number listed on the Automated Eligibility Verification System (AEVS) that Providers, Members or individuals acting on behalf of Members can call at anytime (twenty-four (24) hours/seven (7) days a week) to obtain authorization for all CalOptima Covered Services. Twenty-four (24) hour telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either:

3.41.1 Have authority to approve Covered Services; or

3.41.2 Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and

3.41.3 In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room; and

3.41.4 Respond to Provider's or Member's call within thirty (30) minutes. Failure to respond to such call within thirty (30) minutes shall result in the HMO being liable for the cost of subsequent Medically Necessary Covered Services related to that illness or injury whether or not that treatment has been authorized; and

3.41.5 Have the capability to coordinate continuous care and follow-up Covered Services, including referrals to Specialist Physicians, for all Members who have received MSE or Emergency Services and have been Stabilized.

3.41.6 All calls shall be logged in with time, date and any pertinent information related to persons involved, resolution and follow-up instructions. HMO shall notify CalOptima if the toll free telephone number changes no less than seven (7) working days prior to the change.

3.42 OBLIGATIONS UNDER PRIOR CONTRACT --- HMO acknowledges and agrees that certain of its obligations and duties under the Prior Contract, if previously contracted, survive the expiration of the Prior Contract and/or are measured following the expiration of the Prior Contract (including, without limitation, corrective action plans, quality improvement and credentialing functions, financial requirements). HMO shall perform all such obligations and duties. For purposes of this section, "Prior Contract" means the contract for health care services previously entered into between HMO and CalOptima pursuant to which HMO agreed to provide or arrange for the provision of Medi-Cal Covered Services Members.

3.43 EMPLOYEE EDUCATION ON FALSE CLAIMS ACT --- HMO shall comply with the requirements contained in 42 USC § 1396a(a)(68)(A)-(C) as a condition of receiving payment under this contract. HMO shall, upon request of CalOptima, demonstrate compliance with this provision, including providing CalOptima with copies of HMO's applicable written policies and procedures, any relevant employee handbook excerpts, and other educational materials used to meet this requirement.

3.44 MONITORING --- HMO shall comply with all monitoring provisions of this Contract and the State Contract, and any monitoring requests by CalOptima and DHCS.

3.45 HMO SUBCONTRACTS --- In addition to Section 3.9 of this Contract, HMO shall maintain and make available to CalOptima, DHCS, or other CalOptima's Regulators, upon their respective requests, copies of all Subcontracts. HMO shall ensure that all Subcontracts are in writing and require that the HMO and its Subcontractors:

3.45.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima and/or CalOptima's Regulators, or their designees.

3.45.2 Retain such books and all records and document for a term minimum of at least ten (10) years from the final date of the State Contract period or from the date of completion of any audit, whichever is later.

3.46 CALOPTIMA OVERSIGHT – HMO understands and agrees that CalOptima is responsible for the monitoring and oversight of all obligations of HMO under this Contract. In instances where DHCS or CalOptima determines that the HMO or any of the Subcontractors has not performed satisfactorily, CalOptima shall have the right to (a) amend or revoke the delegation of activities or obligations to the HMO, (b) require the HMO to amend or revoke the sub-delegation of activities or obligations to the Subcontractors, and/or (c) specify other remedies, including, but not limited to, those set forth in Sections 13.1 through 13.1.3.2. HMO shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with applicable laws and regulations, accreditation organization standards, and/or CalOptima Policies governing the obligations of HMO or the oversight of those obligations.

ARTICLE 4
Obligations of HMO – Provision of Covered Services

4.1 PROVISION OF COVERED SERVICES TO MEMBERS --- HMO shall provide Covered Services to Members under this Contract in the same manner as those services are provided to other patients of HMO, but in no case less than the amount of such services provided under the Medi-Cal Fee-for-Service Program. Consistent with the concept that HMO is the medical home of the Member, where the Member receives the majority of the Member's care and where the Member's overall health status, need for care and services, and wellness are assessed, evaluated, monitored, managed, enhanced and/or maintained, HMO shall coordinate Members' needs for Covered Services and provide Care Management Services and other services to assure Members receive all necessary care and services without regard to the party financially responsible for care and services. HMO shall provide Covered Services to Members and HMO agrees as follows:

4.1.1 HMO shall provide and pay for, consistent with the terms and provision of this Contract and CalOptima Policies, the provision of all Covered Services to Members that are the financial responsibility of HMO as set forth in Attachment A, with the exception of certain Medical Supplies identified in Attachment C;

4.1.2 If HMO's network is unable to provide necessary medical services covered under this Contract to a particular Member, HMO must adequately and timely cover these services out of network for the Member, for as long as HMO is unable to provide them. HMO shall make prior arrangements with Out-of-Network Providers for the provision of such

services, and shall be fully responsible for arranging and paying for such services, and shall comply with all applicable CalOptima Policies with regard to the payment and authorization of Out-of-Network Providers;

4.1.3 HMO shall be liable for the provision of and payment for all Covered Services notwithstanding a delay in payment of the Capitation Payment;

4.1.4 CalOptima may incorporate any change in Covered Services mandated by federal or State law or regulation into the Contract effective the date the change goes into effect. Whenever possible, CalOptima shall give the HMO thirty (30) calendar days' notice of any such change. CalOptima shall determine the effective date of the change in Covered Services;

4.1.5 The actual provision of any Covered Service is subject to the professional judgment of the PCP or other physicians participating in the respective HMO as to the Medical Necessity of the service, except that HMO shall provide assessment and evaluation services ordered by a court or legal mandate;

4.1.6 HMO shall comply with Jackson v. Rank, U.S. District Court (E.D. Cal.), No. CIV 5-83-1451 LKK, June 9, 1986, and notify its Members when the HMO denies, modifies or defers a PCP's request for authorization or terminates a previously authorized service;

4.1.7 Decisions concerning whether to provide or authorize Covered Services shall be based solely on Medical Necessity. HMO acknowledges that disputes between the respective HMO and Members about Medical Necessity can be appealed pursuant to CalOptima Policies;

4.1.8 HMO 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. HMO may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose; and

4.1.9 HMO shall hold harmless both the State and Members in the event that CalOptima cannot or will not pay capitation payments pursuant to this Contract. In no event, including but not limited to, non-payment by CalOptima or HMO, CalOptima's or the HMO's insolvency, or breach of this Contract by the HMO or CalOptima, shall HMO or Subcontractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State, a Member or persons acting on the behalf of a Member for Covered Services provided pursuant to this Contract. This provision does not prohibit HMO or Subcontractors from collecting co-payments and deductibles, if any, as specifically provided for in this Contract or for recoveries related to other health coverage, as identified in Section 2.8 of this Contract. HMO or a Subcontractor may bill a Member and collect fees for non-Covered Services from the Member if the Member agrees to the fees in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's Medical Record. HMO further agrees:

4.1.9.1 That this Section shall survive the termination of this Contract for those Covered Services rendered prior to the termination of this Contract, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members;

4.1.9.2 That this Section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the HMO and Participating Providers or Subcontractors;

4.1.9.3 That language to ensure the foregoing shall be included in all of the HMO's Subcontracts with Participating Providers;

4.1.9.4 That no change or amendment to this Section or to similar section(s) in Subcontracts between the HMO and Participating Providers shall be made without the prior written approval of CalOptima; and

4.1.9.5 HMO further agrees that, in the event of a violation of this Section by HMO or Subcontractor, including but not limited to, balance billing of Member for Covered Services provided under the Contract or Subcontract, CalOptima shall take appropriate remedial action against HMO or Subcontractor, including, but not limited to, repayment of any amounts collected, and appropriate Sanctions, as provided for in Section 13.1.

4.2 EMERGENCY CARE --- HMO shall comply with all applicable State and federal laws and regulations governing the provision and payment of Emergency Services, as well as the applicable requirements of the State Contract (including, but not limited to, Exhibit A, Attachment 8, Provision 12). HMO is required to provide and pay for all Emergency Services, including Emergency Services provided by Out of Network Providers, without prior authorization, twenty-four (24) hours each day, seven (7) days a week.

4.2.1 HMO shall reimburse or authorize reimbursement, as appropriate, for all Emergency Services without prior authorization, and in accordance with CalOptima Policy. Payment may be denied only if HMO reasonably determines that Emergency Services were never performed.

4.2.2 HMO shall reimburse or authorize reimbursement for facility changes for Emergency Services. HMO is required to reimburse hospital when necessary for all MSE. If the MSE indicates that the Member has an Emergency Medical Condition as defined in Section 1.34, HMO must reimburse or authorize reimbursement, as appropriate for all Covered Services Medically Necessary to diagnose and Stabilize the Member.

4.2.3 HMO shall reimburse those physicians providing services in an Emergency Department with whom HMO has a contract according to the terms of that contract. HMO shall offer to enter into a contract with any physician group contracting with CalOptima for the provision of physician services in an Emergency Department on the same terms, conditions and rates as provided for in that CalOptima contract. HMO shall reimburse all other non-contracted physicians providing services in an

Emergency Department in accordance with the Deficit Reduction Act of 2005, 42 USC 1396u-2(b)(2)(D), and CalOptima Policy.

4.2.4 HMO shall not retroactively deny a claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition as defined in Section 1.34, turned out to be non-emergency in nature.

4.2.5 An Emergency Medical Condition shall not be limited based on a list of diagnoses or symptoms. HMO shall not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have resulted in an outcome specified in Section 1.34. Further, HMO shall not deny payment for treatment obtained when HMO or a Participating Provider instructs the Member to seek Emergency Services.

4.2.6 HMO shall reimburse the County of Orange for Emergency Services and Urgent Care Services provided to Members at Orangewood Children's Home or while in Foster Care during periods of emergency foster placement or court-ordered stays. Payment shall be based on the prevailing Medi-Cal Fee Schedule.

4.2.7 If there is a disagreement between HMO or any Participating Provider and Out of Network Provider regarding Medically Necessary Covered Services in an emergency, the judgment of the attending physician(s) actually caring for the Member at the treating facility shall prevail. HMO may establish relationships with treating facility whereby the HMO may send a Participating Provider with privileges to assume the attending physician's responsibilities to establish treatment or may arrange to have a Participating Provider and Hospital under contract with HMO agree to accept the transfer of the Member after the Member has been Stabilized. The attending emergency physician, or the Provider actually treating the Member is responsible for determining when the Member is sufficiently Stabilized for transfer or discharge and that determination is binding on HMO.

4.2.8 Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). HMO is financially responsible for post-stabilization services obtained within or outside HMO's network that are pre-approved by a plan provider or other entity representative. HMO is financially responsible for post-stabilization care services obtained within or outside HMO's network that are not pre-approved by a plan provider or other HMO representative, but administered to maintain the Member's Stabilized condition within 1 hour of a request to HMO for pre-approval of further post-stabilization care services.

4.2.8.1 HMO is also financially responsible for post-stabilization care services obtained within or outside HMO's network that are not pre-approved by a plan provider or other entity representative, but administered to maintain, improve or resolve the Member's Stabilized condition if HMO does not respond to a request for pre-approval within 30 minutes; HMO cannot be contacted; or HMO's representative and the treating physician cannot reach an agreement concerning the Member's care and a plan physician is not available for consultation. In this situation, HMO must give the treating physician the opportunity to consult with a plan physician and the treating

physician may continue with care of the patient until a plan physician is reached or one of the criteria of 422.133(c)(3) is met.

4.2.8.2 HMO's financial responsibility for post-stabilization care services it has not pre-approved ends when a plan physician with privileges at the treating hospital assumes responsibility for the Member's care, a plan physician assumes responsibility for the Member's care through transfer, a plan representative and the treating physician reach an agreement concerning the Member's care; or the Member is discharged.

4.2.8.3 Consistent with 42 CFR 438.114(e), 422.1 13(c)(2), and 422.214 HMO is financially responsible for payment for post-stabilization services following an emergency admission at the hospital's Medi-Cal FFS payment amounts for general acute care inpatient services rendered by a non-contracting Medi-Cal certified hospital, unless a lower rate is agreed to in a writing signed by the hospital. For the purposes of this Section, the Medi-Cal FFS payment amounts for dates of service when the post-stabilization services were rendered shall be the Medi-Cal FFS payment amounts established in California Welfare and Institutions Code (W & I) Section 14166.245, which for the purposes of this Section shall apply to all general acute care hospitals, including hospitals contracting with the State under the Medi-Cal Selective Provider Contracting Program (W & I Section 14081 et. seq.), less any associated direct or indirect medical education payments to the extent applicable. Payment made by HMO to a hospital that accurately reflects the payment amounts required by this Section shall constitute payment in full under this Section, and shall not be subject to subsequent adjustments or reconciliations by HMO, except as provided by Medicaid and Medi-Cal law and regulations. A hospital's tentative and final cost settlement processes required by 22 CCR 51536 shall not have any effect on payments made by HMO pursuant to this Section.

4.2.8.4 Consistent with 42 CFR 438.114(e), 422.1 13(c)(2), and 422.214, HMO is financially responsible for payment for post-stabilization services following an emergency admission. HMO shall reimburse those physicians providing post-stabilization services with whom HMO has a contract according to the terms of that contract. HMO shall reimburse all non-contracted physicians providing post-stabilization services in accordance with the Medi-Cal Fee Schedule as defined in CalOptima Policy.

4.3 NEWBORN SERVICES --- HMO shall provide all Covered Services to any newborn child born to a Member for the month of the birth and the following month.

4.4 FAMILY PLANNING --- HMO 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, HMO shall provide Family Planning information to CalOptima, or authorized representatives of the State or federal government or the Member's PCP to maintain consistency of the Member's Medical Record. HMO's Subcontracts with PCPs must include language regarding the confidentiality

of Family Planning documents, information and records. Prior authorization for Family Planning services shall not be required.

4.4.1 HMO shall comply with OBRA 1987, Section 4113(c)(1)(B), which requires HMO to certify that it shall not restrict or prevent a Member from selecting a Participating Provider or an Out of Network Provider to deliver Family Planning Covered Services and supplies. This does not relieve HMO from financial responsibility for such services.

4.4.2 HMO shall not prevent Members from receiving Family Planning Covered Services from Out of Network Providers.

4.4.3 HMO shall provide information that clearly explains the rights of the Member regarding the choice of Family Planning Providers. HMO shall also provide similar information to all Providers who are either PCPs, obstetricians, gynecologists, or urologists. The intent of this information is to implement the specifications of this paragraph by arranging for the availability of consistent and accurate information from the Member's PCP, obstetrician, gynecologist, or urologist about the Member's rights to freedom of choice regarding Family Planning Providers.

4.4.4 HMO shall provide information to Members and Participating Providers about a Member's right to file a grievance or request a State hearing, in accordance with CalOptima Policies, for any reason including if the Member has reason to believe that the HMO has restricted, prevented, impaired or denied the Member's free choice of Family Planning Providers.

4.4.5 HMO shall incorporate specifications of this Section in its Subcontracts with its PCPs, obstetricians, gynecologists, and urologists.

4.5 ANCILLARY SERVICES FOR LONG TERM CARE --- HMO shall provide authorized Covered Services, including ancillary Covered Services for both emergent and routine laboratory tests and x-rays, not included in the facility day rate for all Members residing in Long Term Care Facilities.

4.6 ACCESS TO SERVICES TO WHICH HMO OR A SUBCONTRACTOR HAS A MORAL OBJECTION --- Unless prohibited by law, HMO shall arrange for the timely referral and coordination of Covered Services to which HMO 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.

4.7 ALCOHOL MISUSE SCREENING AND COUNSELING --- HMO 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. HMO shall document AMSC services in Members Medical Records.

4.8 AMERICAN INDIAN HEALTH SERVICE PROGRAMS --- American Indian Health Service Programs can operate as a Primary Care Physician for American Indian Members, and as such can provide referrals directly to network physician without first requesting a referral

from a network Primary Care Physician. HMO shall ensure timely access to American Indian Health Service Programs by including American Indian Health Service Programs within HMO's network for American Indian Members in accordance with 42 CFR 438.14(b).

4.9 PARTICIPATION IN CALOPTIMA WHOLE CHILD MODEL PROGRAM --- HMO acknowledges and agrees that its participation in CalOptima WCM is conditioned on transfer of CCS to CalOptima and meeting DHCS access and other requirements. Upon meeting those conditions, CalOptima shall notify HMO of the date upon which HMO will be considered to be "Participating in the CalOptima Whole Child Model Program" as this phrase is used in this Contract, and at which time HMO shall commence all CalOptima WCM obligations.

ARTICLE 5
Obligations of HMO – Access

5.1 TWENTY FOUR (24) HOUR PHYSICIAN COVERAGE --- HMO shall ensure that a physician Participating Provider or physician employed by HMO is available twenty-four (24) hours a day, seven (7) days a week for timely authorization including, but not limited to, authorizing Medically Necessary post-stabilization care, coordinating the transfer of Stabilized Members in an emergency department, and for general communication with emergency room personnel, if necessary, in accordance with CalOptima Policies. In addition, HMO shall ensure disputed requests for authorizations are timely resolved in accordance with applicable law and regulations, as well as CalOptima Policies.

5.2 URGENT CARE SERVICES --- HMO shall make Covered Services available within twenty-four (24) hours or as appropriate for Urgent Care.

5.3 INITIAL HEALTH ASSESSMENT APPOINTMENT --- HMO shall have a process in place to ensure each Member is scheduled for an initial health assessment within one hundred twenty (120) calendar days following enrollment with CalOptima, unless otherwise directed by CalOptima Policies. At a minimum, an initial health assessment shall include administration of the Staying Healthy Assessment Tool, a medical history, weight and height data, blood pressure, preventive health screens and tests which are required under CalOptima Policies, discussion of appropriate preventive measures, and arrangement of future follow-up appointments as indicated. The initial health assessment shall include the identification, assessment, and development of care plans as appropriate for Members with special health care needs. The initial and periodic health assessment appointments shall include a dental screening/oral health assessment for all Members under 21 years of age and include annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first. HMO shall ensure that Members are referred to appropriate Medi-Cal dental Providers and provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish. CalOptima may establish minimum performance requirements for completion of the initial health assessment. HMO's failure to perform at or in excess of minimum performance requirements shall subject HMO to sanctions in accordance with this Contract and CalOptima Policies. HMO shall ensure that health assessment information shall be recorded in the Member's Medical Record.

5.4 APPOINTMENT FOR PEDIATRIC PREVENTIVE COVERED SERVICES --- HMO shall schedule periodic pediatric screenings in accordance with the American Academy of Pediatrics (AAP) periodic schedule and/or DHCS requirements. Immunizations are to be

provided according to the latest guidelines published by the AAP and the Advisory Committee on Immunization Practices (ACIP). If there are any conflicts in the recommendations, the higher standard shall be recognized. Adults shall receive periodic health assessments according to the guidelines published by the United States Preventive Services Task Force.

5.5 HOSPITAL GEOGRAPHIC DISTRIBUTION --- HMO agrees that each hospital participating in the HMO, shall be located within ten (10) miles or thirty (30) minutes of the PCPs designated service area with active medical staff privileges at each hospital.

5.6 DAYS TO APPOINTMENT---

5.6.1 Non-Emergency Covered Services - HMO shall ensure that appointments are scheduled with a PCP for non-emergency or non-urgent Covered Services within ten (10) business days of a Member's request. HMO shall also have a process in place for follow-up on Member missed appointments.

5.6.2 Specialist Services – HMO shall ensure that appointments are scheduled with Specialists within fifteen (15) business days of request of appointment. HMO shall arrange for the provision of specialty services from specialists outside the network if unavailable within HMO's network, when determined medically necessary.

5.6.3 Preventive Covered Services - HMO shall schedule health assessments and general physical examinations in advance consistent with professionally recognized standards of practice as determined by the treating Provider acting within the scope of his or her practice and in accordance with CalOptima Policies.

5.6.4 Maternity Covered Services - HMO shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request. Subsequent routine appointments shall be scheduled in advance in accordance with applicable Department of Managed Health Care regulations governing timely access to non-emergency health care services. HMO shall cover and ensure the provision of all Medically Necessary services for pregnant Members. HMO shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services.

5.6.5 Measurement - HMO shall periodically measure days to appointment.

5.6.6 The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with Professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Member.

5.6.7 Members shall be offered appointments within the following timeframes:

5.6.7.1 Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;

5.6.7.2 Urgent appointment for services that do require prior authorization– within 96 hours of a request;

5.6.7.3 Non-urgent primary care appointments – within ten (10) business days of a request;

5.6.7.4 Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

5.6.8 In the event that a Provider, including a PCP, is terminated or leaves the HMO for any reason, HMO shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS in accordance with applicable CalOptima Policies and regulatory requirements.

5.7 OFFICE WAITING TIMES --- HMO shall periodically measure office waiting times to ensure compliance with CalOptima Policies, by its subcontracted Participating Providers, and shall take appropriate action to provide notice to Participating Providers if they are not meeting the wait time requirements that they may be sanctioned for such non-compliance up to and including termination of their Subcontract. HMO's failure to monitor and enforce Participating Provider office wait time requirements in accordance with the terms of this Contract may subject HMO to sanctions as set forth in this Contract and CalOptima Policies.

5.8 TIME LIMIT FOR DECISION ON REFERRALS --- HMO shall provide a decision on authorization requests for those Covered Services that are not Urgent Care Services or Emergency Services, including Specialty Physician referrals as set forth in CalOptima's utilization management program. These Covered Services shall be provided or made available to the Member within fifteen (15) calendar days after authorization is granted. HMO shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

5.9 CHANGES IN AVAILABILITY OR LOCATION OF COVERED SERVICES --- Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. HMO's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes. HMO's proposal shall allow for timely notice to Members to allow them to change PCPs if desired, as provided in Section 5.10 of this Contract.

5.10 NOTICES ABOUT PCP CHANGES --- HMO shall give Members thirty (30) calendar days' notice if their PCP withdraws from HMO. All notices sent to Members shall be submitted to CalOptima for prior approval before distribution to Members. Such notices must include instructions for selecting a new PCP should the Member not be satisfied with a new PCP assigned by HMO. With the exception of PCP terminations in which a provider is immediately terminated due to endangering the health and safety of patients, committing criminal or fraudulent acts or engaging in grossly unprofessional conduct, Members not receiving thirty (30) calendar days advance notice of PCP withdrawal shall be permitted to self-refer within HMO for up to sixty (60) calendar days or until a new PCP is chosen by Member.

5.11 CHOICE OF PCP --- HMO shall offer each Member the opportunity to choose a PCP affiliated with the HMO. A Member may elect to obtain primary care services from a contracted non-physician medical practitioner as long as there is a physician who has ultimate responsibility for the Member's Care Management Services. When HMO receives the Member's files from CalOptima and determines that the Member has not indicated a PCP choice, HMO shall assign the Member to a PCP and include information about this assignment with the required enrollment information sent to the Member within seven (7) calendar days of notification of a Member's enrollment in HMO. HMO shall permit Members to change PCPs at least monthly, and to change more often if assignment of a specific PCP would be harmful to the interest of the Member.

5.12. PROVIDERS ELIGIBLE FOR PARTICIPATION IN MEDI-CAL --- Except in emergency situations, HMO shall use only Providers who are eligible for participation in the Medicare and/or Medi-Cal program to provide the Covered Services required under this Contract. Providers shall: (i) not be suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs; (ii) have not ever been suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs based on a mandatory exclusion as defined in 42 U.S.C. § 1396a-7(a); and (iii) have not been convicted of any felony, or any misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with or obstruction of any investigation into health care related fraud or abuse or that has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program, within the previous 10 years.

5.13 PROVIDER TO MEMBER STAFFING RATIOS ---

5.13.1 Provider to Member Ratios - As specified by the State, HMO shall ensure that PCP staffing ratios satisfy the following full-time equivalent provider to Member ratios:

5.13.1.1 Primary Care Physicians 1:2,000 Members;
5.13.1.2 Total physicians 1:1,200 Members; and
5.13.1.3 If Non-physician Medical Practitioners are included in HMO's Network, each individual Non-physician Medical Practitioner shall not exceed a full-time equivalent provider/Member caseload of one (1) provider per 1,000 Members.

5.13.2 Supervising Physicians - HMO shall ensure that physicians who supervise non-physician mid-level staff are certified to supervise by the California Medical Board. As specified by the State, the ratio of physician supervisor to non-physician medical practitioner shall satisfy the requirement of a minimum of one (1) physician to:

5.13.2.1 Four (4) nurse practitioners; or
5.13.2.2 Four (4) physician assistants; or
5.13.2.3 Four (4) non-physician medical practitioners in any combination that does not include more than three (3) certified nurse midwives or two (2) physician assistants.

5.14 PCP GEOGRAPHIC DISTRIBUTION --- HMO shall maintain a network of PCPs, to make available to every Member a PCP whose office is located within thirty (30) minutes or ten (10) miles of Member's place of residence. Nothing in this provision shall be interpreted as preventing a Member from choosing a PCP beyond these geographic limits.

5.15 SPECIALIST GEOGRAPHIC DISTRIBUTION --- HMO shall make available to every Member, Specialists whose offices are located within fifteen (15) miles or thirty (30) minutes from the Member's place of residence as required in W & I Code Sections 14197(b) and (c). HMO shall provide transportation for Members when the nearest available Specialist is more than fifteen (15) miles or thirty (30) minutes from Member's place of residence.

5.16 PHYSICAL ACCESS --- HMO's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

5.17 ACCURACY OF PROVIDER DIRECTORY --- HMO shall notify CalOptima within five (5) business days when either of the following occur:

5.17.1 The Provider is not accepting new Members.
5.17.2 If the Provider had previously not accepted new Members, the Provider is currently accepting new Members.

ARTICLE 6
Obligations of HMO – Clinical Quality

6.1 LICENSURE --- HMO shall ensure that every physician providing Covered Services and employed or engaged by HMO or Subcontractor shall retain at all times during the period of this Contract a valid license to practice medicine issued by the Medical Board of the State of California, without restriction to practice in designated field of medicine.

6.2 HEALTH EDUCATION AND PREVENTION --- HMO shall inform Members of contributions which they can make to the maintenance of their own health and the proper use of health care services and have a program of health education and prevention (HEP) available in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. HMO shall:

6.2.1 Coordinate and integrate with CalOptima's QI Program;

6.2.2 Refer Members to appropriate HEP, based on the Member's needs;

6.2.3 Implement and utilize the Staying Healthy Assessment Tool as defined in CalOptima Policies; and,

6.2.4 Educate Providers and Members regarding Health Education services available to Members.

6.3 CLINICAL LABORATORY IMPROVEMENT AMENDMENTS --- HMO shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of

waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

6.4 QUALITY IMPROVEMENT PROGRAM --- HMO shall participate and cooperate in CalOptima's Quality Improvement Program. HMO shall establish, maintain and operate a Quality Improvement Program, in accordance with the delineation of responsibilities in the Delegation Agreement, which shall include an Annual Program Plan, Work Plan, and Annual Evaluation of Effectiveness of the QI program, which are consistent with current industry standards, Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), Joint Commission, and DHCS, and meets the requirements of CalOptima's Quality Improvement Program. HMO shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of Healthcare Effectiveness Data and Information Set (HEDIS)). HMO shall submit reports related to Quality Improvement as required by CalOptima Reporting Policy or otherwise required by DHCS. HMO shall adopt a detailed written Quality Improvement (QI) Plan, which shall include:

6.4.1 Well defined goals and objectives of the QI Program;

6.4.2 A well-defined scope of the QI Program that considers all different types and levels of care and service provided to Members; and

6.4.3 Clearly defined accountability and responsibility for the QI Program.

6.4.4 The Board of Directors of HMO or a multi-disciplinary QI Committee designated by the Board of Directors of HMO shall oversee the QI Program conducted by HMO. 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 HMO. The QI Committee shall meet at least on a quarterly basis. HMO shall maintain attendance records and meeting minutes related to the QI Program.

6.4.5 The QI Program activities shall be reported in writing to HMO's Board of Directors at least on a quarterly basis. These reports shall be available to CalOptima upon request.

6.4.6 The HMO's QI Program shall include involvement and participation in network-wide studies/projects initiated by CalOptima.

6.4.7 HMO shall develop an annual QI work plan, which includes the following:

6.4.7.1 Goals, scope and planned projects for the year;

6.4.7.2 Planned monitoring of identified issues and tracking these issues over time;

6.4.7.3 Planned studies/audits suggested by CalOptima or the HMO; and

6.4.7.4 An annual evaluation of the QI Program/Plan.

6.4.8 HMO shall have a written procedure for responding to the findings of QI activities, such as collecting data, analyzing results, implementing corrective action plans, and reassessing the same data for improvement.

6.4.9 Requirements for the HMO's QI Program shall be established by the HMO's QI Committee and requirements may change based on changes in industry standards. CalOptima's QI Committee shall notify HMO of any additional changes in QI standards and requirements that shall be incorporated in HMO's QI Program. HMO shall not be required to change QI Program requirements more frequently than once per year.

6.4.10 HMO shall report findings and actions taken as a result of the quality improvement activities to CalOptima at least quarterly. In addition, HMO shall provide, upon request, summaries of QI Committee meetings, findings following review of specific cases and other reviews to CalOptima.

6.4.11 The HMO shall respond promptly to all of CalOptima's requests for: (a) Medical Records; or (b) written responses to quality of care issues or Member complaints.

6.4.12 HMO shall allow CalOptima to use performance data for various program purposes, but not limited to, quality improvement activities, public reporting to consumers, and cost sharing for quality improvement activities, as identified in CalOptima Policy.

6.5 CASE MANAGEMENT SERVICES --- HMO shall offer a comprehensive Case Management Services program that targets medically and socially complex Members in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. The Case Management Services program shall consider the Member as a whole individual taking into consideration not only his/her medical needs but also the individual in context of cultural values, age, disability and self-determination.

6.5.1 HMO shall develop and implement policies and procedures that outline processes to support Case Management Services including but not limited to:

6.5.1.1 Pro-active identification mechanisms of high risk Members;

6.5.1.2 Referral processes;

6.5.1.3 Triage mechanisms with appropriate time frames;

6.5.1.4 Comprehensive assessment processes and formats;

6.5.1.5 Care plan development and care plan implementation guidelines and format;

6.5.1.6 Carve-out service coordination;

6.5.1.7 Documentation and communications processes for all Case Management Services; and

6.5.1.8 Mechanism for evaluation of Case Management Program outcomes.

6.5.2 HMO Case Management Services shall demonstrate the ability to find, receive, and process referrals for Covered Services and Urgent Care Services of Members who meet one (1), or more of the following conditions:

6.5.2.1 Are medically complex, demonstrate an inability to manage their medical condition and are at risk of exacerbation without intervention;

6.5.2.2 Demonstrate high recidivism;

6.5.2.3 Are chronically ill;

6.5.2.4 Have a catastrophic diagnosis;

6.5.2.5 Have inadequate family/community support;

6.5.2.6 Are cost and/or length of stay outliers;

6.5.2.7 Are receiving six (6) or more chronic medications per month;

6.5.2.8 Are transitioning between Providers that may cause continuity of care concerns; and

6.5.2.9 Are Members with Special Health Care Needs.

6.5.3 CalOptima shall be entitled to periodically review HMO's Case Management Services program to determine compliance with Case Management Services standards. HMO shall furnish Case Management Services records and information to CalOptima upon request.

6.5.4 HMO Case Management shall collaborate with CalOptima on cases identified by CalOptima as needing care coordinator interventions.

6.5.5 As a component of the Case Management requirements in this Contract, HMO shall assure that HMO possesses adequate information management systems and capabilities to support Case Management functions and to meet guidelines established by CalOptima in CalOptima Policies.

6.6 OBLIGATION OF HMO UPON TERMINATION OF CONTRACTED PROVIDERS --- HMO shall ensure continuity and coordination of care by notifying Members affected by the termination of a Provider or practice site and assisting them in selecting a new PCP or PCP site. HMO shall notify Members affected by the termination of a PCP or PCP site at least thirty (30) calendar days prior to the effective termination date and assist them in selecting a new PCP or PCP site. HMO shall notify Members being seen regularly by a specialist or specialty group whose contract is terminated at least thirty (30) calendar days prior to the

effective termination date and assist them in selecting a different Provider or site. HMO shall obtain the prior written approval of CalOptima before furnishing such notice, as CalOptima must obtain written approval of DHCS as to form and content. When a Provider's contract is discontinued, and either the Provider or HMO decides to terminate the contract for reasons other than professional review actions; or the Member is seeing one (1) Provider within a group and that Provider discontinues with HMO, but the rest of the group continues its contract with HMO, then HMO shall allow Members to have continued access to that Provider under the following circumstances:

6.6.1 Members undergoing active treatment for a chronic or acute medical condition (in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes) have access to their discontinued Provider through the current period of active treatment or for up to ninety (90) calendar days, whichever is shorter; and

6.6.2 Members in their second (2nd) or third (3rd) trimester of pregnancy have access to their discontinued Provider through the postpartum period.

6.7 WHOLE CHILD MODEL PROGRAM ---

6.7.1 WHOLE CHILD MODEL PROGRAM COMPLIANCE --- Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall be responsible for identifying children with qualifying medical and surgical conditions and coordinating appropriate referrals of children with CCS Eligible Conditions as defined in Title 22, CCR Sections 41515.2 through 41518.9 and agrees to implement the Whole Child Model Program in accordance with this Contract and CalOptima Policies.

6.7.1.1 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

6.7.1.2 To ensure consistency in the provision of CCS Covered Services, HMO shall use all current and applicable CCS Program guidelines, including CCS Program regulations, CCS Program information notices, and CCS numbered letters in developing criteria for use by HMO's Medical Director or equivalent, and other care management staff. When applicable CCS clinical guidelines do not exist, HMO shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Member's CCS Eligible Condition.

The CCS numbered letters are posted by DHCS at the following web address for guidance on providing CCS Covered Services to Members eligible for CCS:

http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

6.7.1.3 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall be responsible for all available Medically Necessary Medi-Cal services that are Covered Services under the CalOptima Medi-Cal Program. Any Medically Necessary CCS Services not available as a CalOptima Medi-Cal Covered Service shall remain the responsibility of the State and the county.

6.7.2 CCS PROVIDER NETWORK --- HMO shall utilize only CCS-Paneled Providers to treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment, HMO shall include in their network an adequate number of CCS Providers able to serve the needs of Members with CCS Eligible Conditions and receive timely access. HMO's network shall include an adequate number of CCS-Paneled Providers who are board-certified in both pediatrics and the appropriate pediatric subspecialty conditions and an adequate number of hospitals and/or facilities that include neonatal intensive care units, CCS-approved pediatric intensive care units, CCS-approved inpatient facilities and special care centers approved by the CCS Program to treat a CCS Eligible Condition. However, Members cannot be limited to a single delegated entity's provider network. HMO must ensure Members have access to all Medically Necessary CCS-Paneled Providers within CalOptima's provider network. In addition, HMO may use an out-of-state Provider, in accordance with APL 17-019, if an in-state CCS Provider does not possess the clinical expertise to appropriately treat the Member's CCS condition. If no in-network CCS-Paneled Provider possesses the clinical expertise to appropriately treat a Member's CCS condition, then CCS delegated HMO shall arrange and pay for, and coordinate the provision of, the Medically Necessary Covered Services to the Member by one or more out-of-network CCS-Paneled Providers who possess the appropriate knowledge and clinical experience. CCS delegated HMO shall implement procedures to identify individuals who may need or who are receiving services from Out-of-Network Providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management.

6.7.3 CCS PROVIDER CREDENTIALING --- HMO shall credential CCS Providers in accordance with the existing credentialing requirements along with the requirements of APL 18-011. DHCS will retain responsibility for paneling CCS specialists. In addition, CCS Providers shall be able to utilize CalOptima's provider grievance process.

6.7.4 COVERED CCS SERVICES --- In addition to other services required to be provided to Members under this Contract, effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall cover CCS Services for Members determined to be eligible in accordance with the CCS Program medical eligibility regulations. Upon diagnostic evidence that a Member under 21 years of age may have a CCS Eligible Condition, HMO shall refer the Member to the county CCS office for eligibility determination.

6.7.4.1 HMO shall ensure assessment and care coordination for the transition of Members who are eligible for CCS Services and receiving services through the CCS Program at the time of the transition.

6.7.4.2 For the identification of Members eligible for CCS Services, HMO shall ensure the following:

6.7.4.2.1 Participating Providers shall perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable likelihood, that a Member has a CCS Eligible Condition.

6.7.4.2.2 Initial referrals of Members with CCS Eligible Conditions shall be made to CalOptima by telephone, same day mail, or fax or other secure electronic system, and CalOptima will submit the referral and medical documentation to the County CCS Program for eligibility determination. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the county CCS Program.

6.7.4.2.3 HMO shall provide all Medically Necessary CCS Services for the Member's CCS Eligible Condition(s).

6.7.4.2.4 If the County denies CCS Program eligibility for a Member referred by HMO, HMO remains responsible for the provision of all Medically Necessary Covered Services to the Member, including EPSDT services.

6.7.5 CONTINUITY OF CARE --- Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall provide continuity of care to CCS-eligible Members transitioning to the Whole Child Model Program in accordance with Welfare and Institution Code Sections 14094.13, Health and Safety Code Section 1373.96, APL 18-011, and as follows:

6.7.5.1 In accordance with Welfare and Institutions Code, Section 14094.13(a)-(d), HMO must allow for continuity of care between Members eligible for CCS Services and CCS Providers, and Providers of Specialized Durable Medical Equipment, with whom there is an existing relationship for up to 12 months after the transition. At its discretion, HMO may extend the continuity of care period beyond the 12 months specified in this Section.

6.7.5.2 For out-of-Network CCS Providers and Providers of Specialized Durable Medical Equipment, HMO must allow for continuity of care under the following conditions:

6.7.5.2.1 The Member has seen the CCS Provider for a non-emergency visit at least once during the 12 months immediately preceding their transition to CalOptima's Whole Child Model Program, or the Member has previously received Specialized Durable Medical Equipment from a DME provider.

6.7.5.2.2 The CCS Provider or Provider of Specialized Durable Medical Equipment accepts HMO's rate for the service, or the applicable Medi-Cal or CCS fee-for-service rate, whichever is higher, unless the CCS Provider enters into an alternative payment methodology mutually agreed upon by HMO and the CCS Provider.

6.7.5.2.3 HMO confirms that the CCS Provider meets applicable CCS standards and has no disqualifying quality of care issues.

6.7.5.2.4 The CCS Provider or Provider of Specialized Durable Medical Equipment makes treatment information available to HMO, to the extent authorized by the State and federal patient privacy provisions.

6.7.5.3 Ensure that the continuity of care requirements for pharmaceutical services and provision of prescribed drugs are applied to Members who are eligible for the CCS Program at the time of the transition to the Whole Child Model Program. Before the previously prescribed drug is discontinued, HMO and the Member's prescribing CCS Provider shall complete the necessary evaluation and treatments and must both agree that the previously prescribed drug is no longer Medically Necessary, or that it is no longer prescribed by the Member's prescribing CCS Provider.

6.7.6 EPSDT SERVICES --- Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, for CCS-eligible Members, HMO shall provide all Medically Necessary Covered Services, including EPSDT services when the scope of an EPSDT benefit is more generous than the scope of a CCS benefit. In such cases, HMO shall apply the EPSDT standard of what is Medically Necessary to correct or ameliorate the Member's condition.

6.7.7 CASE MANAGEMENT AND COORDINATION OF CARE --- Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall provide service authorization, case management, and care coordination for CCS Services by an employee or Subcontractor with knowledge or adequate training on the CCS Program, and clinical experience with either the CCS population or pediatric patients with complex medical conditions.

6.7.7.1 Once a Member's eligibility for the CCS Program is established, CalOptima shall complete the risk level and needs assessment required under APL 18-011. HMO shall provide Complex Case Management services to all Members eligible for CCS Services and coordinate care between the Primary Care Provider, CCS specialty services, and if applicable Outpatient Mental Health Services and regional center services across all settings. The provision of Complex Case Management shall include the facilitation of communication between the Member's health care Providers, personal care Providers such as IHSS and behavioral health Providers, and when appropriate, the Member and/or Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.2 HMO shall also arrange referral to Specialty Mental Health, and Drug Medi-Cal services as appropriate through the county substance use disorder program if determined necessary through CalOptima's assessment. To arrange services with a regional center, HMO shall:

6.7.7.2.1 Coordinate with Members eligible for CCS Services and their parents, custodial parents, legal guardians, or other authorized representatives, in understanding and accessing services; and

6.7.7.2.2 Operate as a central point of contact for questions regarding access, care, and problem resolution.

6.7.7.3 HMO shall create an individual care plan (ICP) for CCS-eligible Members who have been determined high risk through the CalOptima risk stratification process, incorporate the required elements stated in Welfare and Institutions Code, Section 14094.11(c) and APL 18-011, be specific to individual Member needs, and update the ICP at least annually.

6.7.7.4 Provide Person-Centered Planning, case management and coordination of care, to Members eligible for CCS Services and in collaboration with the Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.5 Provide information to Members eligible for CCS Services on how to access local family resource centers or family empowerment centers.

6.7.7.6 Allow a Member eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request continuing case management and care coordination from their public health nurse within 90 days of transitioning to the Whole Child Model Program, in accordance with Welfare and Institutions Code, Section 14094.13(e). If the county public health nurse leaves the CCS Program or is no longer available to provide case management and care coordination, HMO shall transition those services to one of its case managers who has received adequate training on the CCS Program and has clinical experience with the CCS population or pediatric patients with complex medical conditions.

6.7.8 RIGHTS FOR MEMBERS ELIGIBLE FOR CCS ---

6.7.8.1 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall provide a mechanism for a Member eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request a Specialist or clinic as a Primary Care Provider.

6.7.8.2 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, for Members receiving

continuity of care, HMO shall send a written notice 60 days prior to the end of the authorized continuity of care period. The notice shall explain the right to petition HMO for an extension of the continuity of care period, the criteria used to evaluate the petition, and the appeals process if HMO denies the petition.

6.7.8.3 In addition to the Member's right to file a Grievance or request an appeal or State Fair Hearing, effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall also ensure that Members who are eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, may appeal the continuity of care limitations, or the extension of a continuity of care period in accordance with Welfare and Institutions Code, Section 14094.13(i)(1).

6.7.8.4 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall also ensure that CCS-eligible Members, or the Members' parents, custodial parents, legal guardians, or other authorized representatives, retain the right to request an Appeal and State Fair Hearing for adverse benefit determinations that involve delay, modification, denial, or discontinuation of CCS Services in accordance with CalOptima Policy.

6.7.8.5 HMO must ensure Members are provided information on grievances, appeals and State Fair Hearing processes as provided under CalOptima Policies. Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, CCS-Eligible Members enrolled in managed care are provided the same grievance, appeal and State Fair Hearing rights as provided under APL 18-001, and State and Federal law.

6.8 CREDENTIALING REQUIREMENTS --- HMO acknowledges and agrees that CalOptima has delegated credentialing and recredentialing obligations to HMO. HMO shall have an ongoing credentialing and recredentialing program covering Participating Providers (e.g. Practitioners, organizational providers and licensed independent practitioners) consistent with CalOptima Policies and in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. HMO shall comply with all credentialing and recredentialing obligations as specified in this Contract and CalOptima Policies.

6.8.1 HMO shall have a mechanism in place to ensure confidentiality of information collected during the credentialing and recredentialing process.

6.8.2 HMO shall ensure that all Participating Providers who furnish items and/or services to Members and/or submit claims and/or receive reimbursement for Covered Services furnished to Members meet CalOptima's credentialing and recredentialing requirements as specified in CalOptima's Credentialing and Recredentialing Policy. HMO shall ensure that any Participating Provider who is required to meet credentialing and recredentialing requirements, but fails to do so, does not furnish items and/or services and/or receive reimbursement for any Covered Services furnished to

Members. HMO shall ensure that all contracts with Participating Providers who are subject to these requirements allow for termination of the Participating Provider's right to furnish items and/or services to Members and/or submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.8.3 HMO shall provide to CalOptima or have available for CalOptima review upon request the following:

6.8.3.1 An accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHS-6216 (07/05), or such other disclosure form as DHCS may otherwise provide to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations.

6.8.3.2 A signed attestation that all Participating Providers who are required to meet CalOptima Minimum Standards in order to furnish, submit claims and/or receive reimbursement for Covered Services furnished to Members meet CalOptima's Minimum Standards as specified in CalOptima Policies.

6.8.3.3 An annual signed attestation that all Participating Providers are credentialed to the standards set forth by CalOptima and DHCS.

6.8.3.4 Monthly summary of all credentialing and recredentialing activity including the name of Participating Provider, date of facility site review (if applicable) and decision date.

6.8.3.5 Concurrent reporting of any adverse action toward a Participating Provider, including adverse actions reported to a governmental or other regulatory agency.

6.8.3.6 If applicable, Quarterly Summaries and copies of facility site reviews performed for PCPs.

6.9 BOARD CERTIFICATION --- HMO shall ensure that all Practitioners furnishing Covered Services to Members meet those requirements identified in CalOptima Policy regarding Board Certification.

6.9.1 HMO shall ensure that any Practitioner who is required to meet the requirements set forth above, but fails to do so, does not furnish items and/or services to Members, submit claims and/or receive reimbursement for any Covered Services furnished to Members. HMO shall ensure that all contracts with Practitioners who are subject to these requirements allow for termination of the Practitioners' right to furnish items and/or services, submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.9.2 HMO acknowledges that these requirements apply to each individual Practitioner that is affiliated with and/or part of any medical group, independent physician associations (IPA) and/or other organization or entity that contracts with HMO to furnish Covered Services to Members.

6.10 FACILITY SITE/MEDICAL RECORDS REVIEW --- HMO shall participate in collaborative PCP site reviews for shared PCPs in accordance with MMCD Policy Letter specifications and other requirements of DHCS. HMO shall comply with CalOptima Policies related to PCP site reviews including those addressing collaborative programs.

6.11 COORDINATION AND CONTINUATION OF CARE --- HMO shall have systems in place to ensure managed patient care, including at a minimum:

6.11.1 Management and integration of health care, including Covered Services, through a PCP.

6.11.2 Referrals for Medically Necessary specialty, secondary and tertiary Covered Services.

6.11.3 HMO shall clearly specify referral requirements to Participating Providers and Subcontractors and establish a system to track and monitor services requiring prior authorizations through the HMO.

6.11.4 HMO shall have a utilization management program that meets guidelines as set forth in CalOptima Policies and is in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement.

6.11.5 Systems to assure provision of care in emergency situations, including an education process to help assure that Members know where and how to obtain Medically Necessary Covered Services in emergency situations.

6.11.6 The provision of Case Management Services as set forth in this Contract, CalOptima Policies and in coordination with CalOptima's Case Management program.

6.11.7 Systems for the consideration and approval of standing referrals, in accordance with CalOptima Policy.

6.11.8 HMO shall be responsible for coordinating care of certain services including:

6.11.8.1 HMO's Participating Providers providing Pediatric Preventive Services (CHDP) shall document such services on the CMS-1500, UB-04 claim form or electronic equivalent.

6.11.8.2 Participating Providers providing CHDP agree to coordinate with the Orange County CHDP Program as set forth in the CHDP Program pursuant to CalOptima's Pediatric Preventative Services Policy;

6.11.8.3 HMO shall promote education and support systems that increase compliance with the standards for periodicity and content of pediatric health assessments;

6.11.8.4 HMO shall make referrals to the Women, Infants and Children Food Supplementation Program (WIC) in accordance with WIC policies and procedures;

6.11.8.5 HMO shall make referrals for perinatal Members to the PSS program pursuant to CalOptima Policy;

6.11.8.6 HMO shall make referrals to the Regional Center of Orange County (RCOC), as set forth in the RCOC MOU;

6.11.8.7 All Members between the ages of three (3) and twenty-one (21) shall be referred to a dentist in accordance with the most recent recommendations of the AAP, as part of periodic health assessment;

6.11.8.8 HMO shall be responsible for Covered Services that are related to dental services but are not provided by a dentist or dental anesthetists. Covered Services required for a dental procedure include but are not limited to: laboratory services, pre-admission physical examinations required for admission to inpatient and outpatient Facility, anesthesia services, and inpatient surgical services and inpatient hospitalization services as provided in CalOptima Policy. HMO shall develop referral and prior authorization policies and procedures to implement the above requirements. HMO shall submit these policies to CalOptima for review and approval;

6.11.8.9 HMO shall provide outpatient mental health services within the PCP's scope of practice. HMO shall refer Members requiring inpatient mental health services to the Orange County Health Care Agency (HCA) Behavioral Health Services. HMO shall retain financial responsibility for initial physical health assessment for any Member admitted to an inpatient facility. This assessment shall be performed by a facility physician or by the Member's PCP. HMO shall also maintain financial responsibility for any Covered Services that are Medically Necessary while Members are receiving inpatient care including but not limited to laboratory and/or x-ray services.

6.11.8.10 Mental Health Services. HMO shall provide Care Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. This would include the coordination and responsibility for non-mental health services for Members undergoing inpatient psychiatric treatment. CalOptima shall retain financial responsibility for certain mental health psychotherapeutic drugs. HMO shall retain financial responsibility for laboratory tests associated with provision of mental health services, including but not limited to use of psychotropic drugs. HMO shall comply with all responsibilities, policies and procedures as set forth in the HCA/MHP MOU.

6.11.8.11 For Outpatient Mental Health Services, HMO shall refer Members to the CalOptima Behavioral Health for mild to moderate mental health conditions and the Administrative Service Organization (ASO) for Specialty Mental Health services.

6.11.8.11.1 To access mild to moderate Outpatient Mental Health Services that are outside the PCP's scope of practice, HMO shall refer Members to CalOptima's mental health contracted provider through CalOptima Behavioral Health. Members requiring alcohol and or substance use disorder treatment should be referred to the Orange County Drug Medi-Cal Organized Delivery System (DMC-ODS).

6.11.8.12 For outpatient Specialty Mental Health Services, HMO shall refer Members to the Administrative Service Organization (ASO) contracted by Orange County to provide assessment, referral and authorization services for Specialty Mental Health Services.

6.11.8.12.1 HMO shall provide Care Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. DHCS retains financial responsibility for certain mental health psychotherapeutic drugs. HMO shall retain financial responsibility for laboratory tests associated with provision of mental health services, including but not limited to use of psychotropic drugs. HMO shall comply with all responsibilities, policies and procedures as set forth in the HCA/MHP MOU; and

6.11.8.12.2 HMO shall arrange and coordinate Medically Necessary Covered Services, including referral of Members requiring alcohol and drug treatment to Orange County DMC-ODS. Members requiring outpatient heroin detoxification shall be referred to appropriate Providers.

6.11.9 To the extent that the HMO is responsible for the coordination of care for Members, CalOptima shall share with HMO, in accordance with Section 14.12, any utilization data that DHCS has provided to CalOptima, and HMO shall receive the utilization data provided by CalOptima and use it as the HMO is able for the purpose of Member care coordination.

6.12 VACCINES --- HMOs shall assure, at a minimum, all routine pediatric vaccinations currently recommended by the AAP/ACIP and the United States Preventative Task Force and additional routine immunizations are provided to Members consistent with HMO's immunization policy. CalOptima shall not reimburse HMO for the cost of vaccines that are available under the Vaccines for Children (VFC) program. Providers administering pediatric immunizations shall maintain an appropriate supply of vaccines from the VFC program. Vaccinations, which are not part of the standard pediatric protocol, shall be administered according to CalOptima Policies.

6.13 PHARMACY APPROVED DRUG LIST COMPLIANCE --- Participating Providers shall comply with the CalOptima Approved Drug List and its associated drug utilization and disease management guidelines and protocols. Requests for items not included in the Approved Drug List shall require prior authorization by CalOptima. The prescribing physician shall be responsible for submitting prior authorization requests and responding to requests for

additional information in accordance with regulatory timeframes. The prescribing physician shall provide CalOptima all information necessary to process prior authorization requests.

6.13.1 HMO may be subject to sanctions for Participating Provider's failure to comply with the prior authorization process.

6.13.2 Participating Providers shall prescribe generically available drugs instead of the parent brand product whenever therapeutically equivalent generic drugs exist.

6.14 RESEARCH --- HMO agrees to participate in and make data available for research projects initiated or approved by CalOptima.

6.15 FUNCTIONS AND DUTIES OF HMO FOR SPD --- HMO shall provide the following for SPD Members:

6.15.1 INTENTIONALLY LEFT BLANK

6.15.2 HMO shall refer all SPD Members, who require a customized wheelchair and/or a modification to a customized wheelchair or seating system, to a contracted Evaluation Services Provider, and provide appropriate Covered Services in accordance with the resulting evaluation, pursuant to CalOptima Policy;

6.15.3 HMO shall make available Incontinence Supplies to SPD Members when such supplies are Medically Necessary to treat incontinence. HMO shall not restrict the Incontinence Supplies by brand name as long as the supplies do not exceed the rate paid for comparable supplies under the DHCS Medi-Cal Fee-for-Service program;

6.15.4 HMO shall authorize Medical Supplies for six (6) month periods for SPD Members under the following conditions: (a) the PCP determines that the SPD Member requires ongoing Medical Supplies; (b) HMO determines that the Medical Supplies are Medically Necessary based upon the prescribing PCP's assessment; and (c) the PCP projects that the SPD Member's need for the Medical Supplies will remain stable over the six (6) month period;

6.15.5 HMO or Subcontractor shall dispense Medical Supplies in no greater than thirty (30) calendar day amounts, even when such Medical Supplies are authorized for six (6) month periods. HMO shall approve re-authorization of Medical Supplies at consecutive six (6) month intervals unless a PCP determines that a change in the SPD Member's medical condition warrants additional assessment, and/or adjustments to the prescription for Medical Supplies. Notwithstanding a six (6) month authorization, HMO shall not be responsible for providing Medical Supplies when the SPD Member's Medi-Cal eligibility ceases or when the Member is no longer enrolled with the HMO;

6.15.6 HMO shall permit SPD Members to select as a PCP any Participating Specialist Provider willing to perform the role of the PCP. HMO shall provide to all SPD Members upon enrollment HMO and at any time thereafter, upon the SPD Member's request a list of all Participating Specialist Providers willing and available to perform duties/functions of the PCP;

6.15.7 Within one-hundred twenty (120) days upon enrollment in the HMO of an SPD Member, HMO shall complete a plan of care pursuant to CalOptima Policies. HMO shall update this plan as appropriate and/or annually. HMO shall consult the SPD Member and/or Member's representative as appropriate in completing and updating the plan of care;

6.15.8 Upon request, and as Medically Necessary, for any qualifying SPD Member as defined in CalOptima Policies, HMO shall conduct and provide, when appropriate, a home assessment to assess the SPD Member's needs for appropriate referrals to Participating Providers and/or community based organizations and providers;

6.15.9 HMO shall provide SPD Members with standing referrals pursuant to CalOptima Policies, to specialists necessary for conditions requiring ongoing treatment or ongoing supply, equipment or DME service needs. These referrals can be renewed semi-annually; and

6.15.10 HMO shall have Participating Providers with facilities and/or sites that are capable of accommodating SPD Members with special medical care needs as defined in CalOptima Policies. Facility requirements to meet the needs of SPD Members with special medical care needs include, but are not limited to, office or clinic equipment to facilitate the appropriate and safe examination of SPD Members and the capacity to provide specific Covered Services to SPD Members, such as the provision of dental procedures under general anesthesia.

6.15.11 If HMO's network is unable to provide necessary medical services covered under the Contract to a particular SPD Member, HMO must adequately and timely cover these services out-of- network for the Member, for as long as the entity is unable to provide them. HMO acknowledges that out-of-network providers must coordinate with HMO with respect to payment, and HMO shall ensure that such out-of-network providers understand this requirement. HMO must ensure that cost to the Member is not greater than it would be if the services were furnished within the network. HMO shall provide for the completion of covered services by a terminated or out-of-network provider at the request of a Member, in accordance with the continuity of care requirements in Health and Safety Code Section 1373.96. For newly-enrolled SPD Members, HMO shall provide continued access for up to twelve (12) months to an out-of-network provider with whom the Member has an ongoing relationship (i.e. an existing provider from whom they are receiving services), if the provider will accept HMO or Medi-Cal FFS rates, whichever is higher per W & I Code 14182(b)(13) and (14). An ongoing relationship shall be determined by identifying a link between the newly-enrolled SPD Member and an out-of-network provider using FFS utilization data provided by DHCS.

6.15.12 For SPD Members, HMO shall report all grievances related to those listed in Title 28, CCF, Section 1300.68(f)(2)(D), including, but not be limited to, timely assignments to a provider, issues related to cultural and linguistic sensitivity, difficulty with accessing specialists, and grievances related to out-of-network requests.

6.15.13 HMO and Participating Providers and all staff who interact with SPD Members, as well as those who may potentially interact with SPD Members, or any other staff deemed appropriate by CalOptima or DHCS shall receive sensitivity training as provided by CalOptima or DHCS, or by HMO pursuant to DHCS requirements and CalOptima Policies.

6.15.14 Personal Care Coordinator (PCC) Programs for CCS and SPD Members Definitions.

6.15.14.1 Care Management Monthly Profile (Profile)" is a monthly report generated by CalOptima which provides the healthcare risk outcomes for CCS and SPD Members.

6.15.14.2 "Individual Care Plan" is a plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.

6.15.14.3 "Personal Care Coordinator or PCC" is a dedicated non-licensed care coordinator, assigned to each Medi-Cal member with an CCS Eligible Condition as determined by the local CCS Program, or SPD aid code, supervised by a licensed person, and funded by CalOptima.

6.15.14.4 HMO shall employ PCCs, and participate in all PCC Program requirements as defined in CalOptima Policy and the Profile. HMO shall staff one PCC per six hundred (600) CCS or SPD Members assigned to HMO. PCC responsibilities include but are not limited to: Assisting Members and Member's PCPs in the development of an Individual Care Plan (ICP); communicating the ICP with the Member, Member's PCP and Member's care team; and assisting Members receiving care as outlined in the ICP. HMO shall submit required reports and documents to CalOptima. These include but are not limited to ICPs, PCC staffing levels, and PCC and professional staff descriptions to demonstrate adherence CalOptima Policy requirements.

6.15.14.5 CalOptima shall provide HMO with Profile requirements. Changes to the Profile which may impact PCC supplemental capitation, will be communicated to HMO thirty (30) days prior to the effective date of such change. If HMO is unable to agree to the requirements stipulated in the Profile, and no resolution is reached in the thirty (30) day period, further action may be taken including but not limited to recoupment of PCC supplemental funds that have been paid to HMO and termination of the Contract.

6.16 ADVANCE DIRECTIVES --- HMO shall maintain written policies and procedures related to Advanced Directives in compliance with current State law. HMO shall not discriminate against any Member on the basis of that Member's Advance Directive status.

6.17 SECOND OPINIONS --- HMO shall provide, at its sole cost and expense second opinions and provide to Members all required notification, documentation, forms and information regarding obtaining second opinions as prescribed by CalOptima Policies.

6.18 DISEASE MANAGEMENT --- HMO shall assist CalOptima in implementation of a disease management program in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement.

6.19 MEMBERS WITH SPECIAL HEALTH CARE NEEDS --- HMO shall identify, assess and implement care plans as appropriate for Members with Special Health Care Needs. HMO shall have processes for monitoring and tracking Members with Special Health Care Needs and the provision of services under the implemented plan of care.

6.20 MEMBER VISITS --- HMO shall ensure that Subcontracting health facilities licensed pursuant to Health and Safety Code Section 1250 permit a Member at Member's choice to be visited by a Member's domestic partner, the children of a Member's domestic partner, and the domestic partner of the Member's parent or children. HMO shall include the requirement of this Section in its Subcontracts with such health facilities.

6.21 DHCS DIRECTIONS --- If required by DHCS, HMO and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

6.22 Intentionally left blank.

6.23 ENHANCED CARE MANAGEMENT

6.23.1 HMO Participation in CalOptima ECM – HMO shall begin participating as an ECM Provider in CalOptima Enhanced Care Management, as set forth below, for CalOptima Members who meet the DHCS-defined criteria for one of the following Populations of Focus ("ECM Populations of Focus"):

6.23.1.1 For CalOptima adult Members who meet the DHCS-defined criteria for one of the following: (i) Individuals Experiencing Homelessness; (ii) "Individuals At Risk for Avoidable Hospital or ED Utilization (formerly known as "High utilizer"); (iii) Individuals with Serious Mental Illness ("SMI") and/or Substance Use Disorder ("SUD") Needs; (iv) Individuals Transitioning from Incarceration; (v) Individuals with Intellectual or Developmental Disabilities ("I/DD"); or (vi) Pregnancy, Postpartum, and Birth Equity Population of Focus.

6.23.1.2 Effective January 1, 2023, or such later date as determined by DHCS, for CalOptima Members who meet the DHCS-defined criteria for one of the following: (i) Adults Living in the Community and At Risk for Long Term Care (LTC) Institutionalization; or (ii) Adult Nursing Facility Residents Transitioning to the Community.

6.23.1.3 Effective July 1, 2023, or such later date as determined by DHCS, for other CalOptima children and youth who meet the DHCS-defined criteria for one of the following: (i) Individuals Experiencing Homelessness; (ii)

"Individuals At Risk for Avoidable Hospital or ED Utilization (formerly known as "High utilizer"); (iii) Individuals with SMI and/or SUD Needs; (iv) Individuals Transitioning from Incarceration; (v) Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition; (vi) Children and Youth Involved in Child Welfare (including foster care up to age 26); (vii) I/DD; or (viii) Pregnancy, Postpartum, and Birth Equity Population of Focus.

6.23.1.4 Effective January 1, 2024, or such later date as determined by DHCS, for Members who meet the DHCS-defined criteria for one of the following: (i) Pregnancy, Postpartum, and Birth Equity Population of Focus (who are subject to racial and ethnic disparities)..

6.23.2 HMO as an ECM Provider – HMO shall be responsible for providing ECM services as the Member's ECM Provider. ECM Provider shall ensure its systems and infrastructure are in place to provide ECM services to ECM Members. ECM Provider shall implement ECM in compliance with this Contract and CalOptima Policies.

6.23.3 ECM Provider Requirements – HMO, as an ECM Provider, shall satisfy the ECM Provider requirements as set forth in CalOptima Policies and as follows:

6.23.3.1 ECM Provider shall be experienced in serving the ECM Population(s) of Focus it will serve and shall have experience and expertise with the services it will provide.

6.23.3.2 ECM Provider shall comply with all applicable State and federal laws and regulations and all ECM requirements in the DHCS-CalOptima ECM and Community Supports Contract and associated guidance.

6.23.3.3 ECM Provider shall have the capacity to provide culturally appropriate and timely in-person care management activities including accompanying Members to critical appointments when necessary. ECM Provider shall be able to communicate in culturally and linguistically appropriate and accessible ways.

6.23.3.4 ECM Provider shall have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health Providers, Specialists, and other entities, including Community Supports Providers, to coordinate care as appropriate to each Member.

6.23.3.5 ECM Provider shall use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of an ECM Member care plan that can be shared with other Providers and organizations involved in each ECM Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).

6.23.3.6 If a State-level enrollment pathway exists, ECM Provider shall enroll as a Medi-Cal Provider, pursuant to relevant DHCS APLs including APL 19-004: Provider Credentialing/ Recredentialing and Screening/Enrollment. If APL 19-004 does not apply to an ECM Provider, the ECM Provider shall comply with CalOptima's process for vetting the ECM Provider, which may extend to individuals employed by or delivering services on behalf of the ECM Provider, to ensure it can meet the capabilities and standards required to be an ECM Provider.

6.23.4 Identifying Members for ECM – HMO, which also serves as the ECM Provider, shall proactively identify Members who would benefit from ECM and determine on a case by case basis whether identified Members are eligible for ECM in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach.

6.23.5 Member Assignment to ECM Provider

6.23.5.1 CalOptima shall be responsible for making ECM authorization determinations for HMO's enrolled Members in accordance with applicable CalOptima Policies.

6.23.5.2 HMO shall serve as the ECM Provider for all ECM Members enrolled in the HMO, except as otherwise provided in Section 6.23.5.3 of this Contract.

6.23.5.3 HMO acknowledges and agrees that the County of Orange shall serve as the ECM provider for certain ECM Members as specified in CalOptima Policy GG.1356: Enhanced Care Management Administration. HMO shall fully cooperate and coordinate with CalOptima and with the County of Orange, serving as the ECM provider for such ECM Members, in accordance with applicable CalOptima Policies and/or as required by CalOptima to ensure compliance with DHCS requirements for ECM.

6.23.6 ECM Provider Staffing – At all times, ECM Provider shall have adequate staff to ensure its ability to carry out responsibilities for each assigned ECM Member consistent with this Contract, CalOptima Policies, DHCS ECM Provider Standard Terms and Conditions, the DHCS-CalOptima ECM and Community Supports Contract and any other related DHCS guidance.

6.23.7 ECM Provider Outreach and Member Engagement – ECM Provider shall be responsible for conducting outreach to each assigned Member and engaging each assigned Member into ECM, in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach. ECM Provider shall ensure outreach to assigned Members prioritizes those with the highest level of risk and need for ECM.

6.23.7.1 ECM Provider shall conduct outreach primarily through in-person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. ECM Provider may supplement in-person visits with secure teleconferencing and telehealth, where appropriate, with the Member's consent, and in compliance with CalOptima Policies. ECM Provider shall use the following

modalities, as appropriate and as authorized by the Member, if in-person modalities are unsuccessful or to reflect a Member's stated contact preferences: (i) Mail; (ii) Email; (iii) Texts; (iv) Telephone calls; and (v) Telehealth.

6.23.7.2 ECM Provider shall comply with non-discrimination requirements set forth in State and federal law and this Contract.

6.23.7.3 CalOptima and ECM Provider will coordinate to ensure that Members who meet exclusionary criteria as defined in CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach do not receive ECM services.

6.23.8. Initiating Delivery of ECM – ECM Provider shall obtain, document, and manage Member authorization for the sharing of personally identifiable information between CalOptima and ECM, Community Supports, and other Providers involved in the provision of Member care to the extent required by federal law.

6.23.8.1 Member authorization for ECM-related data sharing is not required for the ECM Provider to initiate delivery of ECM unless such authorization is required by federal law. When federal law requires authorization for data sharing, ECM Provider shall communicate that it has obtained Member authorization for such data sharing back to CalOptima.

6.23.8.2 ECM Provider shall notify CalOptima to discontinue ECM under the following circumstances: (i) The Member has met their care plan goals for ECM; (ii) The Member is ready to transition to a lower level of care; (iii) The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or (iv) ECM Provider has not had any contact with the Member after three (3) attempts.

6.23.8.3 When ECM is discontinued, or will be discontinued for the Member, Provider is responsible for sending a notice of action notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is informed of their right to appeal and the appeals process as instructed in the notice of action. ECM Provider shall communicate to the Member other benefits or programs that may be available to the Member, as applicable (e.g., Complex Case Management, Basic PHM, etc.).

6.23.9 ECM Requirements and Core Service Components of ECM – ECM Provider shall ensure ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Medi-Cal Members assigned to the HMO. ECM Provider shall ensure the approach is person-centered, goal oriented, and culturally appropriate.

6.23.9.1 Subject to all applicable requirements set forth in this Contract (including, but not limited to, subcontracting requirements), if the ECM Provider subcontracts with other entities to administer ECM functions, the ECM Provider shall ensure agreements with each entity bind the entities to the terms and conditions set forth in Section 6.23 of this Contract and CalOptima Policies and that its Subcontractors comply with all requirements in DHCS ECM Provider Standard Terms and Conditions and the DHCS-CalOptima ECM and Community Supports Contract.

Notwithstanding any subcontracting arrangements, ECM Provider shall remain responsible and accountable for any subcontracted ECM functions.

6.23.9.2 ECM Provider shall: (i) Ensure each Member receiving ECM has a Lead Care Manager; (ii) Coordinate across all sources of care management in the event that an ECM Member is receiving care management from multiple sources; (iii) Notify CalOptima to ensure non-duplication of services in the event that an ECM Member is receiving care management or duplication of services from multiple sources; and (iv) Follow CalOptima's instruction and participate in efforts to ensure ECM and other care management services are not duplicative.

6.23.9.3 ECM Provider shall collaborate with area hospitals, Primary Care Providers (when not serving as the ECM Provider), behavioral health Providers, Specialists, dental Providers, Providers of services for LTSS and other associated entities, such as Community Supports Providers, as appropriate, to coordinate Member care for ECM.

6.23.9.4 ECM Provider shall provide the following core service components of ECM to each assigned ECM Member in compliance with CalOptima Policies GG.1354: Enhanced Care Management – Eligibility and Outreach and GG.1353: Enhanced Care Management Service Delivery: (i) Outreach and engagement of Members into ECM (ii) Comprehensive assessment and care management plan; (iii) Enhanced coordination of care; (iv) Health promotion; (v) Comprehensive transitional care; (vi) Member and family supports; and (vii) Coordination of and referral to community and social support services.

6.23.9.5 ECM Provider shall ensure the establishment of an ECM Care Team and a communication process between Members' ECM Care Team participants related to services being rendered, in accordance with the requirements set forth in CalOptima Policies.

6.23.9.6 ECM Provider shall complete a health needs assessment and develop a comprehensive, individualized, person-centered care plan for each ECM Member. ECM Provider shall ensure case conferences are conducted by the ECM Care Team and the ECM Member's health needs assessment and care plan are updated as necessary.

6.23.10 Training – ECM Provider shall participate in all mandatory, Provider-focused ECM training and technical assistance provided by CalOptima, including in-person sessions, webinars, and/or calls, as necessary. ECM Provider shall ensure that its staff who will be delivering ECM services complete training required by CalOptima and DHCS prior to participating in the administration of the ECM services.

6.23.11 Data Sharing to Support ECM - CalOptima and ECM Provider agree to exchange available information and data as required by DHCS guidance and CalOptima Policies, including but not limited to notification of hospital emergency department visits, inpatient admissions and discharges, and health history of ECM Members. CalOptima and ECM Provider shall conduct such information and data sharing in compliance with all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements (including applying the minimum necessary standard when applicable), and other federal and California

state laws and regulations. Further, ECM Provider shall establish and maintain a data-sharing agreement with other Providers that is compliant with all federal and California state laws and regulations as necessary. If applicable laws and/or regulations require an ECM Member's valid authorization for release of health information and a legal exception does not apply, ECM Provider may not release such information without the ECM Member's valid authorization.

6.23.11.1 CalOptima will provide to ECM Provider the following data at the time of assignment and periodically thereafter, and following DHCS guidance for data sharing where applicable: (i) Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider; (ii) Non-duplicative Encounter and/or claims data, as appropriate; (iii) Non-duplicative physical, behavioral, administrative and social determinants of health data (e.g., Homeless Management Information System (HMIS data)) for all assigned Members, as available; and (iv) Reports of performance on quality measures and/or metrics, as requested.

6.23.12 Claims Submission and Reporting – ECM Provider shall submit claims for the provision of ECM-related services to CalOptima using the national standard specifications and code sets to be defined by DHCS. In the event ECM Provider is unable to submit claims to CalOptima for ECM-related services using the national standard specifications and DHCS-defined code sets, ECM Provider shall submit an invoice to CalOptima with a minimum set of data elements (to be defined by DHCS) necessary for CalOptima to convert the invoice to an encounter for submission to DHCS.

6.23.13 Quality and Oversight – ECM Provider acknowledges that CalOptima will conduct oversight of ECM Provider's participation in ECM to ensure the quality of ECM and ongoing compliance with program requirements, which may include audits and/or corrective actions. ECM Provider shall respond to all requests from CalOptima for information and documentation to permit ongoing monitoring of ECM.

6.23.14 ECM Data and Reports. HMO shall submit to CalOptima complete, accurate, and timely ECM data and reports in the manner and form acceptable to CalOptima as required by CalOptima Policies or otherwise required by DHCS in order for CalOptima to monitor and meet the following: (i) performance targets; and (ii) its data reporting requirements to DHCS.

6.23.15 ECM Provider's Agent Qualifications - ECM Provider shall verify that the qualifications of all agents (including ECM Provider staff) providing ECM services under this Contract comply with the requirements of this Contract, CalOptima Policies, and DHCS guidance. In addition, for agents that enter into Members' homes or have face-to-face interactions with Members, ECM Provider shall also conduct background investigations, including, but not be limited to, County, State and Federal criminal history and abuse registry screening. ECM Provider shall comply with all applicable laws in conducting background investigations and shall exclude unqualified agents from providing services under this Contract.

ARTICLE 7
Obligations of HMO – Reporting

7.1 DATA REPORTING REQUIREMENTS --- HMO shall comply with the data reporting requirements set forth in this Contract, including but not limited to the requirements specified in Standard Reporting Requirements set forth in CalOptima Policies and Guidelines referred to as the Timely and Appropriate Submission Requirements. HMO shall provide such additional data and modify the form, content, instructions and timetables for the collection and reporting of data as may be required by CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

7.2 ENCOUNTER REPORTING --- HMO shall submit to CalOptima complete, accurate, reasonable and timely encounter data (a) needed by CalOptima in order for CalOptima to meet its encounter data reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's regulators as provided in this Contract and in CalOptima Policies. HMO shall submit encounter data pursuant to standards defined by CalOptima Policies. Upon first receiving member assignments; or changing management companies, business systems, clearinghouse vendors, and/or contractual model; HMO shall begin encounter data file testing within sixty (60) days and complete testing within ninety (90) days. HMO shall be subject to financial penalties and/or sanctions if CalOptima determines that HMO is reporting to CalOptima less than all professional and facility encounters in the CalOptima required format and timelines. HMO shall have twelve (12) calendar days, upon notification by CalOptima, to correct encounters rejected by CalOptima's regulatory agencies, including the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS). Financial penalties or sanctions shall be assessed upon HMO should CalOptima determine that HMO is not meeting the standards as defined in CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

7.3 ANNUAL AUDIT AND FINANCIAL REPORTING REQUIREMENTS --- HMO agrees to provide the results of its annual audited financial statements, including "Letters to Management", if requested, for the prior calendar or fiscal year within one hundred-twenty (120) calendar days of the completion of that year. Financial statements shall be presented in a form specified by CalOptima that clearly shows the financial position of HMO as related to Members. HMO shall allow representatives of CalOptima, upon written request, to verify the financial report.

7.4 FINANCIAL REPORTING --- If HMO is required to file monthly Financial Statements with the DMHC, HMO shall simultaneously file monthly Financial Statements with DHCS. HMO shall prepare financial information requested in accordance with GAAP. Where Financial Statements and projections are requested, these statements and projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 rules found under Title 28, CCR, Section 1300.51 et. seq. Information submitted shall be based on current operations. HMO shall submit financial information consistent with filing requirements of the DMHC unless otherwise specified by DHCS.

7.5 PARTICIPATING PROVIDER NETWORK CHANGES --- HMO shall report in compliance with CalOptima Policies, any changes, including but not limited to additions, deletions and location changes of Providers constituting HMO's provider network.

7.6 HMO ORGANIZATION PROFILE --- HMO shall report in compliance with CalOptima Policies, a profile of the HMO's organization, including, but not limited to, HMO's significant administrative and Provider network contractual relationships.

7.7 PARTICIPATING PROVIDER CONTRACTS --- HMO shall provide to CalOptima copies of all contract templates utilized with Participating Providers. Upon modification, change or replacement by HMO, HMO shall provide CalOptima with copies of current contract templates. In addition, upon request from CalOptima or DHCS, HMO shall provide copies of any Subcontract entered into or amended for purposes of fulfilling HMO's obligations under this Contract.

7.8 DISCLOSURE --- HMO and any Subcontractors shall make available to CalOptima, CalOptima's authorized agents, and appropriate representatives of the State and federal government any of HMO's or Subcontractor's financial records related to HMO's capacity to bear the risk of potential financial losses, or to the Covered Services performed and amounts paid or payable under this Contract. CalOptima recognizes the proprietary nature of this information and shall make all assurances to maintain its confidentiality in accordance with the California Public Records Act.

7.9 REPORTING UNAUTHORIZED DISCLOSURE OF PRIVATE MEMBER INFORMATION --- In the event that HMO, or any of its officers, employees, agents, or Subcontractors, becomes aware of the unauthorized disclosure of confidential Member information, as described in California Welfare and Institutions Code Section 14100.2, or of "personal information," within the meaning of California Civil Code Section 1798.3, HMO shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this Section, "unauthorized disclosure" includes any unauthorized access, whether such access was through inadvertence, mistake, theft, or other means, and whether or not HMO had reasonable control to avoid the disclosure.

7.10 PROVIDER DATA – HMO shall submit to CalOptima complete, accurate, reasonable, and timely provider data and other data and reports (a) needed by CalOptima in order for CalOptima to meets its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima Policies.

7.11 REPORTS AND DATA --- In addition to any reporting obligations under this Contract, HMO shall submit reports and data relating to services covered under this Contract as required by CalOptima, in a form and manner specified by CalOptima, including, without limitations, for purposes of complying with requests for reports and data from CalOptima's Regulators to CalOptima.

7.12 CERTIFICATION OF DOCUMENT AND DATA SUBMISSIONS --- All data, information, and documentation provided by HMO to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR § 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the HMO's letterhead signed by the HMO's Chief Executive Office or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such

Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

ARTICLE 8
Obligations of HMO – Termination

8.1 OBLIGATION UPON TERMINATION --- Upon termination of this Contract, it is understood and agreed that HMO shall continue to provide authorized Covered Services to Members who retain eligibility and who are under the care of HMO at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. For Covered Services provided following the month in which HMO received Capitation Payment and termination occurred, HMO shall be paid according to the Medi-Cal Fee Schedule, as defined in CalOptima Policy applicable to such services in effect on the date the services are provided.

8.2 TERMINATION AND TRANSFER OF CARE --- Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's State Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor State contractor, the HMO shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

8.2.1 HMO agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason. Costs of reproduction shall be borne by HMO.

8.3 TERMINATION PLANS --- HMO shall have a plan for the orderly termination of services under this Contract. HMO shall submit a plan regarding coordination of care and payment of claims to CalOptima at least 60 days prior to expiration or termination of this Contract. The termination plan shall require the written approval of CalOptima.

8.4 APPROVAL BY AND NOTICE TO DHCS --- HMO acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of DHCS. CalOptima and HMO shall notify DHCS of amendments to, or termination of, this Contract. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. HMO acknowledges and agrees that any amendments or modifications shall be consistent with the requirements relating to submission to DHCS for approval.

8.4.1 NOTICE TO THE DEPARTMENT OF MANAGED HEALTH CARE -- In addition, HMO shall notify the Department of Managed Health Care in the event that this Contract is amended or terminated.

ARTICLE 9
Obligations of CalOptima – Financial

9.1 PAYMENT OF CAPITATION ---

9.1.1 Capitation Payment - CalOptima shall withhold from HMO an amount equal to twenty-five percent (25%) of one (1) month's Capitation Payment (Withhold). CalOptima may adjust HMO's Capitation Payment in accordance with Policy FF.3002.

9.1.2 Capitation Payment Schedule - CalOptima agrees to pay Capitation Payment to HMO on or about the fifteenth (15^{th}) of the month for enrolled Member. Capitation Rates shall be daily pro-rated basis based upon the Member's effective date of enrollment with HMO.

9.1.3 Capitation Payment Withhold - CalOptima shall withhold from HMO an amount equal to twenty-five percent (25%) of the monthly Capitation Payment (Withhold). CalOptima may adjust HMO's Capitation Payment on a quarterly basis should the Withhold fall below twenty-five percent (25%) of HMO's current month Capitation Payment. CalOptima may increase this withhold rate in accordance with CalOptima Policy.

9.2 CAPITATION RATE ADJUSTMENTS --- The Capitation Rates may be adjusted by CalOptima during the Contract term to reflect implementation of State or federal laws or regulations, changes in the State budget, the State Contract or DHCS policy, and/or changes in Covered Services. Reimbursement is subject to the DHCS providing funds for the purposes of this Contract. Payment adjustments made by DHCS and/or CMS may be reflected in payments to the HMO. If the State has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to HMO as soon as practicable. Capitation may also be adjusted in the event of de-delegation of any function delegated under this Contract or Delegation Agreement.

9.3 PAYMENTS FOR PERSONS WITH AIDS --- CalOptima shall pay a supplemental capitation rate, and HMO shall provide services to Members with a confirmed diagnosis of Acquired Immune Deficiency Syndrome (AIDS) in accordance with CalOptima Policy.

9.4 CALOPTIMA RIGHT TO RECOVER

9.4.1 Overpayments. HMO acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to HMO, CalOptima shall have the right to recover such amounts from HMO by recoupment or offset from current or future amounts due from CalOptima to HMO under this Contract or any other agreement between the parties, after giving HMO 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 HMO paid by CalOptima against any funds owed to HMO by CalOptima, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

9.4.3 Regulator Recoupment Upon Termination. If following the termination or expiration of this Contract, CalOptima's Regulators find that HMO (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of FFP, CalOptima may elect to recoup such FFP amounts, as allowed by Laws, by either: (1) offsetting such FFP amounts, upon notice to HMO, from any current or future amounts owed by CalOptima to HMO under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or shared risk pool surpluses; or (2) sending an invoice to HMO that payment for such FFP amounts are due to CalOptima within thirty (30) days of HMO's receipt of the CalOptima invoice.

9.4.4 Dispute Resolution. HMO may use CalOptima's provider dispute resolution procedure, as described under CalOptima's Policies, and/or the dispute resolution procedures under this Contract to resolve any disputes related to the calculation or payment of such Deficits or FFP amounts.

9.4.5 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 HMO additional sums in any manner that CalOptima deems at its discretion to be beneficial for CalOptima's Members.

9.6 LIMITATION ON CALOPTIMA'S PAYMENT OBLIGATIONS --- Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay HMO any Capitation Payment shall be subject to CalOptima's receipt of funding from the State.

9.7 DISPUTES --- Any and all disputes related to payments and/or enrollments shall be reported to CalOptima within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance by HMO.

9.8 BONE MARROW AND ORGAN TRANSPLANTATION --- In the event that a Member assigned to HMO is actively listed on a DHCS-certified transplant provider list, then the Member will be disenrolled with HMO and enrolled in CalOptima Direct pursuant to CalOptima Policy. For Bone Marrow transplants, Members will be enrolled in CalOptima Direct upon referral to a designated transplant center for a qualifying diagnosis pursuant to CalOptima Policy. Except as provided herein, HMO is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.9 PAYMENT FOR TRANSPLANT EVALUATION --- For Members receiving transplant evaluation services, at a designated DHCS-approved transplant center for the specific transplant type being requested, payment or reimbursement shall be in accordance with CalOptima Policy.

9.10 ADULT MEMBERS DIAGNOSED WITH HEMOPHILIA --- In the event that an adult (age 21+ years) Member assigned to HMO is actively diagnosed as a hemophilia patient, then on the first of the month following diagnosis and notification of CalOptima the adult Member will be disenrolled with HMO and enrolled in CalOptima Direct pursuant to CalOptima

Policy. Except as provided herein, HMO is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.11 ADULT MEMBERS DIAGNOSED WITH END STAGE RENAL DISEASE (ESRD) --- In the event that an adult (age 21+ years) Member assigned to HMO is actively diagnosed as an ESRD patient then on first of the month following submission and acceptance of the CMS-2728 – US to the CalOptima Finance Department the adult member will be disenrolled with HMO and enrolled in CalOptima Direct pursuant to CalOptima Policy. Except as provided herein, HMO is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.12 FALSE CLAIMS ACT POLICY – Providers receiving more than five (5) million dollars in a year are required to have a policy to educate employees about the False Claims Act and other State and Federal laws.

ARTICLE 10
Obligations of CalOptima – Administrative

10.1 Not Applicable to this Contract.

10.2 COMPREHENSIVE HMO AUDIT --- CalOptima shall conduct and HMO shall agree to a full comprehensive compliance audit to be conducted at HMO administrative offices and/or Facilities and/or via desktop/virtual review annually, or as deemed necessary, by CalOptima. CalOptima shall submit results of the HMO audit in writing to the HMO. HMO may rebut and dispute audit findings pursuant to CalOptima Policies. HMO is responsible for implementing the corrective measures (if any). CalOptima retains the right to publish data obtained from the audit. HMO acknowledges and agrees that CalOptima may publish the audit data to Members and/or the general public without further notice to or consent from HMO.

10.3 ENCOUNTER DATA AUDIT --- On an annual basis, CalOptima shall conduct an Encounter audit. The audit shall consist of CalOptima requesting a percentage of each HMO's Member Medical Records. These records shall be reviewed for services provided. These services shall then be compared to reported Encounters to determine if the HMO accurately reported all Encounters.

10.4 INTENTIONALLY LEFT BLANK

10.5 INTENTIONALLY LEFT BLANK

10.6 POLICIES AND PROCEDURES AVAILABILITY--- CalOptima shall provide or make available for HMO copies of current CalOptima Policies relevant to the provisions of this Contract. Copies of current CalOptima Policies relevant to the provisions of this Contract may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.7 MOU AVAILABILITY--- CalOptima shall provide or make available for HMO copies of current MOUs entered into by CalOptima that are binding on HMO within seven (7) working days of execution. Copies of current MOUs entered into by CalOptima that are binding on

HMO may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.8 INTERPRETATION OF MOUs --- CalOptima shall provide or make available for HMO interpretation of MOUs entered into by CalOptima that are binding on HMO. Interpretation of MOUs will identify duties, obligation and responsibilities of HMO.

10.9 RELEASE OF PERFORMANCE INFORMATION AND DATA --- HMO acknowledges and agrees that CalOptima may release to Providers, Members and others without further notice to HMO, information and data relating to the performance of HMO that CalOptima determines among other things would contribute to Providers', Members' and others' evaluation of options and alternatives and/or making informed selections and decisions regarding health care and the provision of Covered Services.

10.10 PROVIDER COMPLAINT SYSTEM --- CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider and HMO shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policy related to CalOptima Medi-Cal Program. HMO complaints, grievances, appeals, or other disputes regarding any issues arising under the Contract shall be resolved through this system.

10.11 RISK ARRANGEMENTS DISCLOSURE --- CalOptima shall provide timely notice regarding those items provided for under Subsections (a)(1) through (a)(3) of Section 1300.75.4.1 of Title 28 of the California Code of Regulations.

10.12 DISCLOSURES ---

10.12.1 ANNUAL FINANCIAL RISK DISCLOSURE – On the Contract anniversary date each year, CalOptima shall disclose to HMO the financial risk assumed under the Contract by providing to HMO the following information for each and every type of Risk Arrangement (including, but not limited to, Medicare Advantage, Medi-Cal, commercial, point of service, small group, and individual plans) covered under this Contract:

10.12.1.1 A division of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to HMO, a hospital(s) or CalOptima under the Risk Arrangement.

10.12.1.2 Expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, PCP, specialist, pharmacy, injectables, home health, durable medical equipment, ambulance and other), as well as the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by each and every type of Risk Arrangement.

10.12.1.3 All factors used to adjust payments or risk-sharing targets, including, but not limited to, the following: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including copayment/deductible levels.

10.12.1.4 The amount of payment for each and every service to be provided under the Contract, including any fee schedules or other factors or units used in determining the fees for each and every service. To the extent that reimbursement is made pursuant to a specified fee schedule, the fee schedule shall be incorporated into the Contract by reference, and shall specify Medicare resource-based relative value scale ("RBRVS") year if RBRVS is the methodology for the fee schedule development. For any proprietary fee schedule, the Contract shall include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

10.12.2 ANNUAL DISCLOSURE OF CAPITATION PAYMENTS – On the Contract anniversary date each year, CalOptima shall disclose to HMO the amount of capitation payments to be paid per member per month.

10.12.3 CAPITATION DEDUCTION DETAIL – CalOptima shall provide to HMO sufficient details to allow HMO to verify the accuracy and appropriateness of any deductions from capitation payments made by CalOptima including, but not limited to, member name, member number, member date-of-birth, billing provider name, date-of-service, procedure/service codes billed, and amount paid.

ARTICLE 11
Obligations of CalOptima – Termination

11.1 MEMBER AND PROVIDER COMMUNICATION --- CalOptima shall approve all HMO, Member and provider communications relating to termination of this Contract, prior to distribution.

11.2 APPROVAL OF HMO TERMINATION PLANS --- CalOptima shall review and approve HMO termination plans at intervals and frequencies established by CalOptima Policies.

11.3 RELEASE OF WITHHOLD --- CalOptima shall release HMO's capitation withhold to HMO upon the latter of nine (9) months following the termination, or upon CalOptima's validation of completion by HMO of all post-termination requirements contained in this Contract and CalOptima Policy. In the event that all post-termination requirements have not been met within nine (9) months following termination, CalOptima may, at its sole discretion, apply HMO's capitation withhold funds to satisfy unmet post-termination requirements.

11.4 Not Applicable to this Contract.

ARTICLE 12
Health Care Delivery System

12.1 OUT-OF-COUNTY SERVICES --- HMO may contract with out-of-county facilities for Covered Services for CalOptima Members provided that the HMO ensures that it coordinates the Member's care and complies with all access, quality and other CalOptima requirements.

ARTICLE 13
Termination and Modification of Contract Terms

13.1 SANCTIONS AND TERMINATIONS FOR CAUSE --- If HMO fails to fulfill any of its duties and obligations under this Contract, including but not limited to: (i) committing acts to discriminate among Members on the basis of their health status or requirements for health care services; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the HMO by Members whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under the provisions of this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's Compliance Program, including Participation Status requirements; (vi) committing fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; (vii) failure to ensure that all Minimum Standards are met; (viii) failure to enforce claims payment prohibitions on providers who are denied the right to submit claims and/or receive reimbursement for services furnished to CalOptima Members; (ix) not having the required amounts and types of financial reserves; (x) failure of Participating Providers to comply with the prior authorization process and other pharmacy requirements as determined by CalOptima; (xi) failure to meet Medical Loss Ratio requirements; (xii) failure to meet minimum enrollment requirements; (xiii) failure to meet quality and/or performance requirements; (xiv) failure to comply with organization structure requirements as set forth in Section 3.10 of this Contract; (xv) failure to submit Encounter Data pursuant to this Contract and CalOptima Policy; (xvi) a failure to perform an obligation or duty under the Prior Contract and/or failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, and (xvii) a violation of the Department of Managed Health Care's Risk Bearing Organization regulations, including reporting, auditing or Corrective Action Plan compliance violations. CalOptima may take any of the actions described below:

13.1.1 Corrective Action Plan (CAP) - CalOptima may require a CAP in the event that any report, audit, survey, site review or investigation indicates that the HMO or any Subcontractor(s) is not in compliance with any provision of this Contract or other Medi-Cal program requirement. A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the HMO or any Subcontractors. CalOptima shall issue a written notice of deficiency and shall require that a CAP to be submitted within fourteen (14) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP.

13.1.2 General Sanctions - Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the HMO is not in compliance with the provisions of this Contract, CalOptima Policies and minimum performance requirements as established by CalOptima.

13.1.2.1 All monetary fines are payable to CalOptima within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice.

Failure to submit payment to CalOptima for any monetary fines within the thirty (30) calendar day period shall result in CalOptima deducting the penalty plus the administrative fee from the HMO's Capitation Payment.

13.1.2.2 HMO may appeal CalOptima's decision to impose a sanction, by filing a complaint pursuant to CalOptima Policies. HMO shall exhaust this administrative remedy, including requesting a hearing according to CalOptima Policy, before commencing a civil action.

13.1.3 Termination for Cause - Notwithstanding and in addition to any other provisions of this Contract, CalOptima may terminate this Contract for cause effective upon thirty (30) calendar days' written notice. Cause shall include, but shall not be limited to, the actions set forth in Section 13.1. HMO may appeal CalOptima's decision to terminate the Contract for cause by filing a complaint pursuant to CalOptima Policies. HMO shall exhaust all administrative remedies before commencing any civil action.

13.1.3.1 In the event of a "Termination for Cause" as provided by this Section, CalOptima may procure, upon such terms and in such manner as it shall deem appropriate, supplies or services similar to those terminated. HMO shall be liable to CalOptima for any excess costs for the provision of such similar supplies or services. In addition, HMO shall be liable to CalOptima for administrative costs or other damages incurred by CalOptima in procuring such similar supplies or services. CalOptima shall also charge an administrative fee when paying a claim on behalf of HMO.

13.1.3.2 CalOptima's rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

13.2 TERMINATION FOR INSUFFICIENT CALOPTIMA MEDI-CAL ENROLLMENT --- CalOptima reserves the right in accordance with CalOptima Policies to terminate the HMO in the event that membership falls below five-thousand (5,000) total members at any time based upon a three (3) month rolling average of HMO membership.

13.3 TERMINATION FOR FAILURE TO MEET QUALITY REQUIREMENTS --- CalOptima may terminate this Contract immediately should HMO fail to comply with or fail to be in compliance with quality requirements as may be established and modified from time to time by CalOptima and/or DHCS.

13.4 TERMINATION FOR FAILURE TO MEET MEDICAL LOSS RATIO REQUIREMENTS --- CalOptima may terminate this Contract with thirty (30) days written notice should HMO fail to comply with or be in compliance with medical loss ratio requirements established in this Contract and CalOptima Policies.

13.5 TERMINATION OF STATE CONTRACT --- CalOptima may terminate this Contract immediately upon termination of the State Contract.

13.6 TERMINATION UPON LOSS OF WAIVER --- This Contract shall terminate immediately upon written notice from CalOptima to HMO that HHS has withdrawn its approval of the waiver granted under Section 1915(b) of the Social Security Act for COHS.

13.7 TERMINATION FOR HMO ORGANIZATION AND OPERATIONS STRUCTURE --- CalOptima may terminate this Contract immediately should HMO fail to comply with requirements for HMO's organization and operation structure established in this Contract and CalOptima Policies.

13.8 Not Applicable to this Contract.

13.9 TERMINATION FOR CONVENIENCE --- Either party may terminate the Contract for convenience, without cause, by giving one hundred eighty (180) calendar days advance written notice to the other party prior to the effective date of such termination.

13.10 TERMINATION FOR HMO INSOLVENCY --- If HMO becomes insolvent, HMO shall immediately advise CalOptima, and CalOptima shall have the right to terminate the Contract upon the same terms and conditions as a "Termination for Cause", set forth in Section 13.1. In the event of the filing of a petition for bankruptcy by or against HMO or a principal Subcontractor, HMO shall assure that all HMO'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 HMO until HMO fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining any and all withheld amounts as necessary to ensure that all HMO obligations have been met.

13.11 TERMINATION BY HMO FOR CAUSE --- Provided that HMO is not in default hereunder, HMO may terminate this Contract for cause upon thirty (30) calendar days' prior written notice to CalOptima. Cause shall mean CalOptima's failure for a period of thirty (30) calendar days to pay the Capitation Payment due to HMO under this Contract. Termination shall be effective at the end of the thirty (30) calendar day notice period, unless CalOptima pays to HMO any such past due payments.

13.12 MODIFICATIONS OR TERMINATIONS TO COMPLY WITH LAW --- CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by the State Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify HMO in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements and HMO shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

13.13 PERFORMANCE MEASURE AND PAYMENTS TO HMO --- CalOptima may establish key performance measures of HMO to set minimum contract performance thresholds and/or pay financial incentives to Health Network. CalOptima may take the following actions, at it sole discretion, based upon the results of such performance measures: require corrective action plans, impose sanctions against HMO, terminate this Contract, and establish Capitation Rates and other payments to HMO.

13.14 PROHIBITION ON USE OF CERTAIN PROVIDERS --- HMO agrees as follows:

13.14.1 CalOptima reserves the right to require HMO, 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, provided that the imposition of the foregoing prohibition shall not terminate this Contract.

13.14.2 CalOptima requires that HMO Participating Providers and/or Subcontractors who do not meet all of Minimum Standards as described in applicable CalOptima Policies, be prohibited from furnishing items or services and/or submitting claims and/or receiving reimbursement for items and/or services furnished to Members. CalOptima may also require that HMO terminate a Participating Provider's right to furnish items or services and/or submit claims and/or receive reimbursement for items and/or services furnished to Members based on the denial of such Participating Provider's right to participate in CalOptima Direct whether based on a credentialing, recredentialing and/or peer review decision.

13.15 NOTICE OF NON-RENEWAL --- In order for CalOptima to facilitate Member transition to other Health Networks, HMO shall provide CalOptima with an advance notice of non-renewal of the Contract in accordance with Section 13.9 prior to the end date of the Contract term in the event HMO elects not to participate in any extension period or new contract term.

13.16 Not Applicable to this Contract.

13.17 EXTENSION, RENEWAL, OR MODIFICATION --- Any extension, renewal, or modification of this Contract shall be made by written amendment signed by the parties, upon formal approval by CalOptima Board of Directors, and in accordance with Section 8.4 of this Contract.

ARTICLE 14
Miscellaneous

14.1 INTERPRETATION OF CONTRACT LANGUAGE --- CalOptima has the right to final interpretation of the Contract language when disputes arise. HMO has the right to appeal disputes concerning Contract language to CalOptima.

14.2 INDEPENDENT CAPACITY OF HMO --- CalOptima and HMO agree that HMO and any agents or employees of HMO, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima.

14.3 NO WAIVER OF IMMUNITY OR PRIVILEGE --- Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

14.4 OMISSIONS --- In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose

of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

14.5 GOVERNING LAW AND VENUE --- This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract between CalOptima and DHCS. HMO shall be required to bring all legal proceedings against CalOptima in State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceeding shall be brought in the Central District Court of California.

14.6 WAIVER --- No delay or failure by either party hereto to exercise any right or power accruing upon non-compliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

14.7 SEVERABILITY--- If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to Members and if the remainder of this Contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

14.8 FORCE MAJEURE --- Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes.

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

14.10 ASSIGNMENT OR DELEGATION --- HMO agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in HMO or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of HMO or Subcontractor; (iii) the merger, reorganization, or consolidation of HMO or Subcontractor with another entity with respect to which HMO or Subcontractor is not the surviving entity; and/or (iv) a change in the management of HMO or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of HMO or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

14.11 NO LIABILITY OF COUNTY OF ORANGE --- As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the HMO hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the

obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefore.

14.12 CONFIDENTIALITY OF RECORDS --- As a condition of access to any record utilized or maintained by DHCS, the Declaration of Confidentiality, a copy of which is incorporated into this Contract as Attachment D, shall be signed and filed with DHCS for every individual prior to that individual being allowed access to computer files or any other data or files which are made confidential by statute, including identification of individual Members.

14.13 DEBARMENT CERTIFICATION --- By signing this Contract, the HMO agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

14.13.1 By signing this Contract, the HMO certifies to the best of its knowledge and belief, that it and its principals:

14.13.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

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

14.13.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in this Section herein; and

14.13.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

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

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

14.13.2 If the HMO is unable to certify to any of the statements in this certification, the HMO shall submit an explanation to CalOptima.

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

14.13.4 If the HMO knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

14.14 SMOKE FREE WORKPLACE --- Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, HMO certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. HMO further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

14.15 AIR OR WATER POLLUTION REQUIREMENTS--Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. HMO agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

14.16 LOBBYING RESTRICTIONS AND DISCLOSURE CERTIFICATION -

14.16.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

14.16.2 Certification and Disclosure Requirements

14.16.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment F, consisting of one page, entitled “Certification Regarding Lobbying”) that the recipient has not made, and will not make, any payment prohibited by Section 14.16.2.2.

14.16.2.2 Each recipient shall file a disclosure in the form set forth in

Attachment F, entitled "Standard Form-LLL 'Disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds to include profits from any covered federal action in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Section 14.16 if paid for with appropriated funds.

14.16.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under this Section herein. An event that materially affects the accuracy of the information reported includes:

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

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

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

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

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

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

14.17 NOTICES --- All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the party to whom notice is given, or seventy-two (72) hours after mailing by United States mail first class, Certified Mail or Registered Mail, return-receipt-requested, postage-prepaid, addressed to the party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima

Attention: Director of Contracting
505 City Parkway West
Orange, California 92868

To: HMO

_____
_____
_____
_____

14.18 GOVERNMENT CLAIMS ACT --- HMO shall ensure that HMO and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et seq.), including, but not limited to Government Code section 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

14.19 DISPUTE RESOLUTION.

14.19.1 Meet and Confer. For any dispute not subject to or resolved by the provider appeals process, or if either party has a dispute it seeks to address informally, the parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The parties shall meet and confer within thirty (30) days of a written request submitted by either party in an effort to settle any dispute. At each meet-and-confer meeting, each party shall be represented by persons with final authority to settle the dispute. If either party fails to meet within the thirty (30)-day period, that party shall be deemed to have waived the meet-and-confer requirement, and at the other party's option, the dispute may proceed immediately to arbitration under Section 14.19.2.

14.19.2 Arbitration. If the parties are unable to resolve any dispute arising out of or relating to this Contract under Section 14.19.1, either party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or

Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the parties, two from each side; provided, however, that nothing stated in this section shall prevent a party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The parties shall share the costs of arbitration equally, and each party shall bear its own attorneys' fees and costs.

14.19.3 Exclusive Remedy. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 14.19.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the provider appeals or meet-and-confer processes.

14.19.4 Waiver. By agreeing to binding arbitration as set forth in Section 14.19.2, the parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

ARTICLE 15
SIGNATURES

15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; (II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS CONTRACT SHALL BE FROM JANUARY 01, 2024, THROUGH JUNE 30, 2027 AND FIVE (5) ADDITIONAL ONE-YEAR AUTOMATIC EXTENSIONS (JULY 1 THROUGH JUNE 30) EXCEPT AS DIRECTED OTHERWISE BY THE BOARD.

IN WITNESS WHEREOF, CalOptima and Monarch Health Plan, Inc. have executed this Contract:

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim_____
PRINT NAME	PRINT NAME
_____	Chief Operating Officer_____
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT A- (EFFECTIVE January 1, 2024)
CalOptima Medi-Cal Division of Financial Responsibility

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Physician	Hospital	Other
Acupuncture	**X**		
Allergy Testing & Treatment			
Testing	**X**		
Serum	**X**		
Immunotherapy injections	**X**		
Ambulance	**-See Transportation-**		
Amniocentesis	**X**		
Anesthesia-for medical diagnosis (Includes Medical, Dental, Mental Health, etc….)			
Professional component	**X**		
Facility component		**X**	
Birth Control	**-See Family Planning-**		
Blood and Blood Products			
From blood bank		**X**	
Transfusions, blood and blood components		**X**	
Autologous Transfusion (including collection of)		**X**	
Outpatient Transfusion, Blood and Blood Components		**X**	
Breast Implant (post-mastectomy) or Removal (medically necessary only)			
Professional component	**X**		
Facility component		**X**	
Breast Reconstructive Surgery (after cancer)			
Professional component	**X**		
Facility component		**X**	
CBAS			**CalOptima (Claims)**
CHDP	**-See Pediatric Preventative Services-**		

	Physician	Hospital	Other
Chemotherapy			
Professional component	**X**		
Outpatient Facility component		**X**	
Medication	**-See Medication-**		
Chiropractic Services	**X**		
Cosmetic Surgery (Medically Necessary)			
Professional component	**X**		
Facility component (licensed surgical center or acute care facility only)		**X**	
Dental Services			
General dental services-Including teeth			**Denti-Cal**
Oral Maxillofacial Surgery (Repair or accident/injury; medically necessary-Excluding teeth)			
Professional component	**X**		
Facility component		**X**	
Anesthesia Services (related to dental services)			
Professional component (Other than provided by Dentist)	**X**		
Professional component (Provided by Dentist)			**Denti-Cal**
Facility component		**X**	
Detoxification – Medical (inpatient acute medical facility only)			
Professional component	**X**		
Facility component		**X**	
Diagnostic Services, (Outpatient) Including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs and solutions required for the service)			
Professional component	**X**		
Facility component	**X**		
Diagnostic Services (Inpatient), Including Radiology			
Professional component	**X**		
Facility component		**X**	
Dialysis			
Professional component	**X**		
Facility component		**X**	

	Physician	Hospital	Other
Durable Medical Equipment (DME) (including insulin pumps) and Medi-Cal covered Glucose Continuous Monitors			
Inpatient		**X**	
Outpatient (including supplies necessary for use of the equipment i.e. oxygen tubing, dressings, blood glucose meters)	**X**		
Custom Wheelchair Assessment (excluding those conducted through MTP)	**X**		
Customer Wheelchair Assessments through MTP			**OC HCA/ State**
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital		**X**	
Emergency Services (hospital based)			
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	**X**		
Facility component, i.e. room use, surgical and medical supplies, and the technical component of diagnostic testing.		**X**	
Mental Health Post Triage / Emergency Stabilization Treatment – admitted to inpatient psychiatric facility			**OC HCA/ State**
Enteral and Parenteral Nutrients, Pumps and Supplies	***-See Nutritional Products -***		
EPSDT Services[2]			
Acupuncture	**X**		
Autism Screening	**X**		
Audiology	**X**		
Chiropractic	**X**		
Cochlear Implant	**X**		
Dental Services			**State**
EPSDT Case Management	**X**		
Hearing Aid Batteries	**X**		
In-Home Private Duty Nursing (PDN)			***CalOptima (Claims)***
Mental Health – Specialty Outpatient			**OC HCA/ State**
Medical Nutrition Services	**X**		
Occupational Therapy[1]	**X**		
Orthodontic Services			**Denti-Cal**
Pediatric Day Health Care Services (CCS)			**State**
Speech Therapy	**X**		

	Physician	Hospital	Other
Family Planning (all provider types)			
Professional component	**X**		
Surgically implanted sterilization devices		**X**	
IUDs (with or without medication)	**X**		
Contraceptive items/supplies billed by a non pharmacy provider	**X**		
Condoms, diaphragms and cervical caps when billed by a Pharmacy			**DHCS PBM**
Medications	**-See Medications-**		
Genetic Disease Screening			
Prenatal Triple Marker Screening			***DHCS Genetic Disease Branch***
Follow-up services for positive prenatal screening			***DHCS Genetic Disease Branch***
Newborn screening panel		**X**	
Other Genetic Testing/Counseling	**X**		
Hearing Aids	**X**		
Hearing Screening	**X**		
Home Health Care			
Care for medical conditions		**X**	
Care for psychiatric conditions			**OC HCA / State**
Injectable medications	***-See Medication -***		
Home infusion	***-See Medication -***		
Home Health and Home Infusion Pumps & Supplies (including Total Parenteral Nutrition Supplies)		**X**	
Hospice Services (ALL levels of services at any facility/location/setting)		**X**	
Hospitalization – Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided In lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)			
Acute Medical		**X**	
Psychiatric			**OC HCA / State**
Hyperbaric Oxygen Therapy		**X**	
Immunizations	***- See Preventive Services -***		

	Physician	Hospital	Other
Laboratory Services			
Inpatient – Medical (technical component)		**X**	
Inpatient – Psychiatric			**OC HCA / State**
Inpatient – Medical (professional component)	**X**		
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**		
Emergency Room	***- See Emergency Services -***		
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities			
Room and Board (facility daily rate)			**CalOptima (Claims)**
Professional services	**X**		
Ancillary services	**X**		
Mammography and Screening	**X**		
Medical/Surgical Supplies and Dressings			
Inpatient		**X**	
Outpatient Medical/Surgical Supplies and Dressings			
Disposable Medical Supplies (including Medi-Cal Categories: Enteral, Tracheostomy, Ostomy, Urological, Wound Care, Infusion Tubing) and Supplies billed by a non-Pharmacy provider	**X**		
Other Disposable Medical Supplies when billed by a Pharmacy			**DHCS PBM**
Medication			
Inpatient			
Acute Medical		**X**	
Acute Psychiatric			***OC HCA/ State***
Long Term Care Facility			**DHCS PBM**
Outpatient Medication billed by a Pharmacy			**DHCS PBM**
Outpatient Medication billed by non-Pharmacy Providers			***CalOptima (Claims)***

	Physician	Hospital	Other
Mental Health			
Behavioral Health Professional Services			
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing			***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit			***OC HCA/ State***
Electroconvulsive Treatment (psychiatrist)			***OC/HCA/ State***
Applied Behavior Analysis (ABA)			***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)		**-In OC- Service is NOT a Medi-Cal Benefit-**	
Behavioral Health Facility			
Acute Care Facility ER not resulting in psych admission		**X**	
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit			**OC/HCA/ State**
Partial Hospitalization Program or Intensive Outpatient PHP, IOP		**-In OC-Service is NOT a Medi-Cal Benefit-**	
Electroconvulsive Treatment Outpatient		**X**	
Substance Use Disorder (SUD) Professional			
Outpatient-Office-Mild to Mod, Medication Assisted Treatment (MAT)-Psychiatrist			**CalOptima (Claims)**
Outpatient-DMC Provider, Intensive Outpatient - DMC Provider			**Drug Medi-Cal**
ER-SUD Consultation			**CalOptima (Claims)**
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**		
Substance Use Disorder (SUD) Facility			
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)		**X**	
Acute Care Facility (Voluntary Inpatient Detox)			**DHCS**
Residential (Detox/Rehab)			**Drug Medi-Cal**
Neuropsych Testing	**X**		

	Physician	Hospital	Other
Nuclear Medicine Diagnostic and Treatment/Therapy			
Professional Component	**X**		
Facility Technical Component (hospital & free-standing centers)		**X**	
Nutritional Dietetic Counseling/Medical Nutrition Therapy/ Health Education	**X**		
Nutritional Products			
Total Parenteral Nutrients (TPN) when provided by Pharmacy			***DHCS PBM***
Total Parenteral Nutrition (TPN) when provided by non-Pharmacy provider			***CalOptima (Claims)***
Total Parenteral Nutrition (TPN) supplies and pumps		**X**	
Enteral Nutrition products included in the DHCS Enteral Nutrition product list			**DHCS PBM**
Enteral Nutrients, Supplies and Pumps	**X**		
Other Nutrition Products when not covered by DHCS PBM	**X**		
Obstetrical Care			
Outpatient diagnostic services	**X**		
Inpatient professional component	**X**		
Inpatient facility component		**X**	
Emergent diagnostic (OB Unit)		**X**	
Ultrasound	**X**		
Perinatal care (Includes 60 days postpartum)	**X**		
Perinatal Support Services			***CalOptima (Capped & Claims)***
Fetal Monitoring			
Professional component	**X**		
Facility component		**X**	
Occupational Therapy	***- See Rehabilitation -***		
Orthotics	**X**		
Outpatient Diagnostic Services	***-See Diagnostic Services (Outpatient) -***		
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)			
Professional component	**X**		
Facility component		**X**	
Out of Area Services	**Follows appropriate DOFR Section**		
Pharmacy	***- See Medication -***		
Physical Therapy	***- See Rehabilitation -***		

	Physician	Hospital	Other
Physician Services			
Inpatient	**X**		
Outpatient	**X**		
Podiatry Services	**X**		
Pediatric Preventive Services (includes CHDP)			
Well Child Visits	**X**		
Immunizations (Ages 0-18 years)			
Vaccine			***VFC (Vaccines for Children Program)***
Administration fee	**X**		
Immunizations (19 years and over)			
Vaccine billed by a non-Pharmacy provider (inclusive of Medi-Cal administration fee)	**X**		
Vaccine billed by a Pharmacy			**DHCS PBM**
Adult Periodic Health Exams	**X**		
Prosthetic Devices			
Surgical implantation	**X**		
Surgically implanted device/prosthetic		**X**	
Non-implanted device/prosthetic	**X**		
Radiation Therapy			
Professional component	**X**		
Facility component		**X**	
Radiology Services	***- See Diagnostic Services -***		
Rehabilitation – Physical, Occupational, & Speech Therapy			
Inpatient professional component	**X**		
Inpatient facility component		**X**	
Outpatient professional component[1]	**X**		
Outpatient facility component[1]	**X**		
Long Term Care Facility	**X**		
Skilled Nursing Facility			
Custodial – Long Term Care	***- See Long Term Care Services -***		
Short stay	***- See Hospitalization -***		
Speech Therapy	***- See Rehabilitation -***		
Termination of Pregnancy			
Professional component (including Mifepristone/RU-486)	**X**		
Facility component		**X**	
Transgender Services			
Professional component	**X**		
Facility component		**X**	

	Physician	Hospital	Other
Transplants – Including Procurement			
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)			***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)			***CalOptima (Claims)***
All Other Transplants (e.g. bone, cornea, skin)			
Professional component	**X**		
Facility component		**X**	
Transportation (includes ambulance)			
Emergency		**X**	
Non-Emergency Medical Transportation (NEMT)		**X**	
Non-Medical Transportation (NMT)			***CalOptima (Claims)***
Tuberculosis (TB) Treatment			
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)			***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA			***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**		
Vision Care			
Routine adult and child eye refraction examination			***CalOptima (TPA)***
Contact lenses			***CalOptima (TPA)***
Lenses and Frames			***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**		
Intraocular lens – surgically implanted		**X**	
Ophthalmological services	**X**		
Prosthetic eye	**X**		
Whole Child Model-Previously California Children's Services			
Professional component including all Special Care Center services billable on a professional claim	**X**		
Facility component including all Special Care Center services billable on a facility claim		**X**	
Maintenance and Transportation			***CalOptima (Claims)***
Medical Therapy Program			***OC HCA / State***
CalOptima reserves the right to determine the ultimate payor for any given service.			
[1] *Services are the responsibility of MTP if provided under the MTP program.*			
[2] *Services listed under the EPSDT are considered to be a guideline and not a benefit, financial responsibility is listed in the appropriate categories within DOFR for EPSDT services.*			

ATTACHMENT B

DISCLOSURE FORM

_____
Name of Provider

The undersigned hereby certifies that the following information regarding _____ (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

_____

_____

Co-Owner(s):

_____

_____

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

_____

_____

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

_____

_____

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

_____

_____

Dated: _____ Signature: _____

Name: _____
(Please type or print)

Title: _____
(Please type or print)

ATTACHMENT C

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ATTACHMENT D

LETTER OF AUTHORIZATION PROCEDURES RELEASE/ACCESS OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES COMPUTER FILES FOR THE MEDI-CAL PROGRAM

DECLARATION OF CONFIDENTIALITY

As a condition of obtaining access to information concerning procedures or other data records utilized/ maintained by the Department of Health Care Services (DHCS) and CalOptima, I, _____, agree not to divulge any information obtained in the course of my assignment to unauthorized persons, and I agree not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

Access to such data shall be limited to _____, _____ fiscal agent, State and federal personnel who require the information in the performance of their duties and to such others as may be authorized by CalOptima.

I recognize that unauthorized release of confidential information may make me subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

_____
Signed

_____
Date

ATTACHMENT E
Capitation Rates

Effective July 1, 2024

Payments by CalOptima to Health Network for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Child/Adult	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40-64 years, Both			
	65+ years, Both			
Medi-Cal Expansion	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			ALL RATES REDACTED
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40- 64 years, Both			
	65+ years, Both			
SPD	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40- 64 years, Both			
	65+ years, Both			
WCM	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-21 years, Female			
	19-21 years, Male			

Aid Code	Age & Gender	Base	Base	Total

				Cap
Category	**Category**	**Hospital**	**Physician**	**Rate**
ESRD	All ages, Both			
AIDS	All ages, 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 policy.

Supplemental OB Delivery Care Payment will be payable for all qualified deliveries based on DHCS guidance.

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment - All			

ATTACHMENT E-1

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ATTACHMENT E-2
DISTRIBUTION OF PROPOSITION 56 FUNDING

This Attachment E-2 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima and HMO shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program.

The California Healthcare, Research and Prevention Tobacco Tax Act (Prop 56), allocates a specified portion of the tobacco tax revenue to fund health care expenditures. Medicaid agencies are required to make supplemental payments to physicians for certain procedures as set forth in amendments to the State Medicaid Plan.

CalOptima agrees to make certain Prop 56 increases to HMO which HMO agrees to pay to Eligible Contracted Providers who render Qualifying Services (both as defined in this Attachment E-2) effective July 1, 2017 and CalOptima agrees to pay HMO an administrative fee to administer such Prop 56 increase payments as provided in this Attachment E-2.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment E-2:

    a. "Eligible Contracted Provider" shall mean a Provider who is contracted with HMO to provide Medi-Cal services to CalOptima members. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Programs, and cost-based reimbursement clinics, however, do not qualify as Eligible Contracted Providers.

    a. "Qualifying Services" shall mean services described by the Proposition 56 Medi-Cal Physician Supplemental Payment Program, which may be revised to include additional CPT codes, rate adjustments, and extensions.

    b. Notwithstanding the above, services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.

2. HMO shall administer the Prop 56 increase in accordance with the Addendum for the applicable State fiscal year attached to this Attachment E-2, applicable state and federal requirements and CalOptima policies. HMO shall forward to Eligible Contracted Providers rendering Qualifying Services an additional payment for the Qualifying Services in accordance with the Attachments to this Attachment E-2 in addition to any payment paid by HMO to the Eligible Contracted Provider under their existing contractual arrangements.

3. CalOptima will forward Prop 56 increase payment funding for the initial payments required to be paid by HMO for Qualifying Services furnished by Eligible Contracted Providers for a State fiscal year based on fee-for-service and capitated claims and encounters submitted by HMO, in accordance with the reports required in Section 5, and accepted by CalOptima. For subsequent payments, once Provider payment is confirmed, based on the monthly reports required by

CalOptima in order for it to fulfil state and federal obligations related to the Prop 56 Increase, CalOptima will reimburse HMO for payments made during the prior reporting period. CalOptima will not make payments for clean or accepted encounters for Qualifying Services received by HMO more than one year after the date of service.

4. HMO shall not provide supplemental Prop 56 payments under this Attachment E-2 to any Provider who is not an Eligible Contracted Provider and all such payments shall be for Qualifying Services. Any Proposition 56 funds paid to an ineligible Provider or for non-qualifying services shall constitute an overpayment, which shall be recouped from such Provider by HMO.

5. On a monthly basis, HMO must report to CalOptima, within 15 days of the end of each calendar month, all supplemental Prop 56 payments made pursuant to this Attachment E-2, either directly by HMO or by HMO's delegated entities and subcontractors at HMO's direction. Reports shall include all supplemental Prop 56 payments made during the month. HMO must provide these reports in a format specified by CalOptima, which at a minimum shall include CPT code, service month, payor (i.e. HMO, or delegated entity or subcontractor), and rendering provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

6. CalOptima will pay HMO a two percent (2%) administrative fee (the "Administrative Fee") once CalOptima has confirmed that the required Prop 56 increase payments have been made by HMO to Eligible Contracted Providers based upon the reports required under Section 5 above. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on confirmed Prop 56 increase payments and shall be remitted to the HMO.

7. CalOptima's obligation to pay HMO any Administrative Fees is contingent upon administrative component payments by DHCS to CalOptima for the Prop 56 increase. In no event shall CalOptima be obligated to pay Administrative Fees to HMO if CalOptima has not received funding for administration of the Prop 56 increase from DHCS.

8. HMO shall make payments to Eligible Contracted Providers for Qualifying Services in conjunction with the payment of the claim for the service. Payments for Qualifying Services may be made retrospectively or in conjunction with the claim payment as applicable. This includes claims payments made effective July 1, 201-7 and after.

9. HMO acknowledges that DHCS has indicated that payments to Eligible Contracted Providers will be verified by DHCS. In the event that future DHCS reconciliation of the Prop 56 increase payments identifies invalid payments, HMO shall return such Prop 56 increase payments to CalOptima immediately upon notice from CalOptima.

10. HMO agrees to provide to CalOptima promptly, upon request, such data, information and reports as required by CalOptima in order for it to fulfill state and federal obligations related to the Prop 56 Increase.

11. HMO and its subcontractors agree to comply with all applicable Federal and State laws and regulations, contract requirements, CalOptima polices and DHCS guidance, including APLs, Policy Letters, and Plan Letters related to the Prop 56 increase.

12. To ensure proper implementation of the supplemental Prop 56 payments, HMO shall ensure that the requirements of this Attachment E-2 are included in the contracts with its subcontractors responsible for making payments to physicians directly providing services to Members.

13. HMO shall have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a supplemental Prop 56 payments in accordance with contract requirements for other payments. In addition, HMO shall identify a designated point of contact for provider questions and technical assistance.

14. As long as the State of California extends the Prop 56 increase payments to CalOptima, CalOptima will continue to make Prop 56 increase payments to HMO, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

15. Notwithstanding other provisions of this Attachment E-2, effective July 1, 2020, CalOptima and HMO shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program pursuant to Section 2.7.18 of the Contract.

ATTACHMENT E-2, ADDENDUM 1

SFY 2017 – 18 (dates of service between July 1, 2017 and June 30, 2018)

HMO shall make the initial payment to Eligible Contracted Providers for dates of service July 1, 2017 through and including April 30, 2018 ("Initial Payment") as reflected on claims submitted to HMO prior to April 30, 2018, no later than July 29, 2018. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below. Subsequent payments to Contracted Eligible Providers shall be made by HMO in accordance with the terms of this Attachment E-2.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	
99202	Office/Outpatient Visit New	
99203	Office/Outpatient Visit New	
99204	Office/Outpatient Visit New	
99205	Office/Outpatient Visit New	ALL
99211	Office/Outpatient Visit Est	RATES
99212	Office/Outpatient Visit Est	REDACTED
99213	Office/Outpatient Visit Est	
99214	Office/Outpatient Visit Est	
99215	Office/Outpatient Visit Est	
90791	Psychiatric Diagnostic Eval	
90792	Psychiatric Diagnostic Eval with medical Services	
90863	Pharmacologic Management.	

ATTACHMENT E-2, ADDENDUM 2

SFY 2018 – 19 (dates of service between July 1, 2018 and June 30, 2019)

HMO shall make the Initial Payment to Eligible Contracted Providers for dates of service July 1, 2018 through and including April 30, 2019, including any adjustments to payments previously made related to services provided during those dates, as reflected on claims submitted to HMO. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below, no later than June 12, 2019. Subsequent payments to Contracted Eligible Providers shall be made by HMO in accordance with the terms of this Attachment E-2, and must be made within 90 calendar days of receiving a clean claim or accepted encounter for qualifying services, for which the clean claim or accepted encounter is received by HMO no later than one year after the date of service.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	
99202	Office/Outpatient Visit New	
99203	Office/Outpatient Visit New	
99204	Office/Outpatient Visit New	
99205	Office/Outpatient Visit New	
99211	Office/Outpatient Visit Est	
99212	Office/Outpatient Visit Est	
99213	Office/Outpatient Visit Est	ALL
99214	Office/Outpatient Visit Est	RATES
99215	Office/Outpatient Visit Est	REDACTED
90791	Psychiatric Diagnostic Eval	
90792	Psychiatric Diagnostic Eval with medical Services	
90863	Pharmacologic Management.	
99381	Initial Comprehensive Preventive Med E&M (<1-year-old)	
99382	Initial Comprehensive Preventive Med E&M (1-4 Years old	
99383	Initial Comprehensive Preventive Med E&M (5-11 years old)	
99384	Initial Comprehensive Preventive Med E&M (12-17 Years old)	
99385	Initial Comprehensive Preventive Med E&M (18-39 Years old)	
99391	Periodic comprehensive preventive med E&M (<1-year-old)	
99392	Periodic comprehensive preventive med E&M (1-4 years old)	
99393	Periodic comprehensive preventive med E&M (5-11 years old)	
99394	Periodic comprehensive preventive med E&M (12-17 years old)	
99395	Periodic comprehensive preventive med E&M (18-19 years old)	

ATTACHMENT1 E-3
DISTRIBUTION OF GEMT QAF FUNDING

This Attachment E-3 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima and HMO shall administer the Ground Emergency Medical Transport (GEMT) Quality Assurance Fee (QAF) Program.

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), DHCS established the GEMT QAF program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by non-contracted emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

Per DHCS guidance, CalOptima and HMO, as its delegated entity, are required to provide increased reimbursement to Eligible Non-Contracted Providers for GEMT service codes for Qualifying Services. HMO must reimburse Eligible Non-Contracted Providers a differential totaling up to $_____ that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency) and A0433 (ALS2) provided during SFY 2018-19 (July 1, 2018 to June 30, 2019).

CalOptima agrees to pay GEMT QAF Program supplemental payment for these adjustments to HMO, and HMO agrees to reimburse Eligible Non-Contracted GEMT Providers who render Qualifying Services (as defined in this Attachment) for Qualifying Services effective July 1, 2018 to June 30, 2019. CalOptima further agrees to pay HMO an administrative fee to administer such GEMT QAF Program payments as provided in this Attachment.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment:

    a. "Eligible Non-Contracted Provider" shall mean a Provider who is not contracted with HMO to provide GEMT services or a Provider who is contracted with HMO for transportation services, but not contracted with HMO to provide GEMT services to CalOptima Medi-Cal members.

    b. "Qualifying Services" shall mean services described by the GEMT QAF Program, which may be revised to include additional CPT codes, add-on adjustment payments, and extensions.

2. HMO shall identify eligible claims for the GEMT QAF Program and reimburse for the specified codes the differential payments totaling up to $_____ for Qualifying Services furnished by Eligible Non-Contracted Providers. HMO is required to make timely payments in accordance with DHCS guidelines for clean claims or accepted encounters for qualifying transports submitted to the HMO within one year after the date of service.

3. HMO shall continue to make payments for dates of service July 1, 2018 through June 30, 2019 for eligible claims in conjunction with the payment of the claim for service. Payment for the GEMT QAF Program may be made retrospectively or in conjunction with the claims payment as applicable.

4. HMO is required to submit GEMT payment adjustment confirmation reports by the 10th of the month. Upon receipt of the confirmation report, CalOptima will reconcile the report and reimburse the GEMT QAF Program payment adjustments separate from the capitation payments, plus a 2% administrative fee

calculated based upon total GEMT payment adjustments. CalOptima shall process these payments by the 20th of the month.

5. HMO and its subcontractors agree to comply with all applicable Federal and State laws and regulations, contract requirements, CalOptima policies and DHCS guidance, including APLs, Policy Letters, and Plan Letters related to the GEMT QAF Program add-on payments.

6. HMO shall have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a GEMT Program differential payment adjustments in accordance with contract requirements for other payments. In addition, HMO shall identify a designated point of contact for provider questions and technical assistance.

7. GEMT QAF funds and expenses shall not be included in any shared risk program calculation or reconciliation.

8. As long as the State of California extends the GEMT Program differential payment adjustments funding to CalOptima, CalOptima will continue to make GEMT Program differential payment adjustments to HMO based upon the submitted confirmation report, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

9. HMO shall comply with any extension of the GEMT QAF funding beyond June 30, 2019 and/or changes to the reimbursement amount required by DHCS. CalOptima will communicate these changes to HMO by means of a Notice to this Contract.

10. Notwithstanding other provisions of this Attachment E-3, effective July 1, 2020, CalOptima and HMO shall administer the Ground Emergency Medical Transport (GEMT) Quality Assurance Fee (QAF) Program pursuant to Section 2.7.18 of the Contract.

ATTACHMENT E-4

SUPPLEMENTAL PAYMENT FOR HOME HEALTH AGENCY SERVICES

On September 17, 2018, DHCS received federal approval for State Plan Amendment 18-0037 to sunset the one percent (1%) payment reduction for home health agency services and to increase reimbursement rates in effect on June 30, 2018, for state plan home health agency services by fifty percent (50%) effective July 1, 2018. Certain procedure codes, that mainly apply to pediatric Medi-Cal members, provide increased Medi-Cal reimbursement rates for certain home health agency services effective July 1, 2018. These supplemental payments will only apply to the cost of services that are not considered part of California Children Services, also known as Whole Child Model covered services.

To obtain the supplemental payment, HMO will submit encounter data to CalOptima for procedures codes, Z5804/S9123, Z5805, Z5806/S9124, Z5807, Z5832/G0299, Z5833/T1002, Z5834/G0300, Z5835/T1003, Z5836/G0162, Z5838/G0156, Z5840/T1016 and Z5868/T1026 or equivalent HIPAA compliant codes evidencing the HMOs' reimbursement of the home health agency services at the increased rates during the period of July 1, 2018, through June 30, 2019. CalOptima will review the encounters eligible for supplemental payment made July 1, 2018, through June 30, 2019 at two different points in time. The initial reconciliation will be for payments made and submitted to CalOptima by October 15th, 2019 at which point CalOptima will make payment by November 30th, 2019. The final reconciliation will be for payments made and submitted by April 15th, 2020 at which point CalOptima will make payment by May 31st, 2020. CalOptima shall validate that services are not CCS covered services prior to payment.

The supplemental payment shall not be applicable to dates of service after June 30, 2019, since the cost changes are incorporated in CalOptima's regular rebasing exercise which are inclusive of forward trend assumptions. Expenses for CCS Eligible Conditions shall be subject to Risk Corridor reconciliation per the Contract and in accordance with CalOptima Policy.

ATTACHMENT E-5

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ATTACHMENT E-6

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ATTACHMENT E-7

MEDI-CAL RATE ENHANCEMENT

For the period from January 1, 2024 through August 31, 2024, the HMO rates set forth in Attachment E for the Child/Adult and SPD aid code categories shall be increased by ___%. This rate enhancement shall not apply to the capitation rates for ESRD and AIDS aid code categories, the Whole Child Model and Medi-Cal Expansion base capitation rates in Attachment E, or the Funding for Enhanced Care Management (ECM) Services in Attachment E-8. Following August 31, 2024, the __% increase shall cease, and the rates under the Contract shall revert to pre-COVID-19 PHE levels unless the Contract is further amended by the parties.

ATTACHMENT E-8

Funding for Enhanced Care Management (ECM) Services

Effective January 1, 2024, subject to approval by DHCS, CalOptima shall make an ECM Supplemental Payment to HMO for ECM services provided to an ECM Member, in accordance with the terms and conditions of CalOptima Policy FF.4002.

1. ECM Services Supplemental Payment

   1.1 CalOptima shall pay HMO the ECM Supplemental Payment rate of $[redacted] PMPM for each Member who receives two (2) or more hours of ECM services in a given month as identified by eight (8) or more units, subject to HMO's compliance with all of the following conditions:

   - Member is identified as an ECM-eligible Member as determined by CalOptima based on ECM eligibility criteria as defined by DHCS and in accordance with CalOptima Policy GG.1354;
   - Member is authorized to receive ECM services;
   - Member receives one of the ECM core service components (as set forth in Section 6.23.9.4 of the Contract) in the prior month;
   - The ECM services are billed and reported to CalOptima consistent with CalOptima Policy FF.4002 and DHCS requirements; and;
   - If applicable, the HMO paid the provider for the ECM services; and
   - The HMO authorized such ECM services.

   1.2 For purposes of this Attachment E-8 only, the term "PMPM" means an all-inclusive case rate that applies whenever HMO, as the ECM Provider, has provided the minimum level of service payable to an enrolled Member. This rate is paid on the basis of submitted claims and is not to be considered a capitation payment.

2. HMO shall submit ECM billing data for the ECM Services Supplemental Payment in accordance with CalOptima Policy FF.4002.

3. Upon validation of the ECM billing data and in accordance with CalOptima Policy FF.4002 CalOptima shall pay ninety (90) percent of all clean claims within thirty (30) calendar days of the date of receipt and ninety-nine (99) percent of all clean claims within ninety (90) calendar days of the date of receipt. The date of receipt shall be the date CalOptima receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

4. In addition to Section 9.4 of this Contract, HMO agrees to CalOptima's recovery of any overpayment of ECM Services Supplemental Payment in accordance with CalOptima Policy FF.4002.

ATTACHMENT E-9

Incentive Payment Program Requirements for Enhanced Care Management (ECM) Services

1. Incentive Payment Program Payment. As part of the CalAIM Program, DHCS has implemented an incentive payment program ("Incentive Payment Program") to, among other things, provide funds for Medi-Cal managed care plans like CalOptima to distribute, in part, to providers to recruit and train an experienced and diverse workforce, as well as expand the ECM provider network through outreach, engagement, and development.

Upon DHCS approval of the Incentive Payment Program, the HMO shall receive a one-time payment of $_____ from CalOptima for the initial fifty percent (50%) of program year one for submission of the gap filling plan. HMO shall, in return, comply with the requirements of the Incentive Payment Program, as set forth in this Contract, and DHCS guidance.

2. Incentive Payment Program Requirements. If the HMO is unable to meet the Incentive Payment Program requirements listed in Section 1, CalOptima may recoup a portion, or all the incentive payment funds paid to HMO under this attachment. The portion of funds to be returned by HMO to CalOptima shall be based upon HMO's level of compliance with the Incentive Payment Program requirements, as determined by CalOptima in its sole and reasonable discretion using a standard set of parameters for all ECM providers receiving payments from CalOptima under the Incentive Payment Program. If HMO does not remit payment to CalOptima within thirty (30) days of receiving written notice from CalOptima of a recoupment under this Section 2, CalOptima may offset such owed amounts from any amounts that CalOptima otherwise owes HMO under this Contract or another agreement between the parties. Distribution will be made based on the payment methodology approved at the December 20, 2021, CalOptima Board of Directors meeting.

3. Termination. CalOptima reserves the right to recoup or offset any and all Incentive Payment Program funds, in accordance with the procedures and requirements set forth in Section 2, if HMO no longer provides ECM services under the Contract.

ATTACHMENT F-1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____	_____
Name of Contractor	Printed Name of Person Signing for Contractor
_____	_____
Contract / Grant Number	Signature of Person Signing for Contractor
_____	_____
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

ATTACHMENT F-2

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348 - 0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier , if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned 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 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.

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.

MEDICARE ADVANTAGE – HMO SERVICES CONTRACT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY DBA CALOPTIMA

AND

_____

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MEDICARE ADVANTAGE HMO SERVICES CONTRACT

This Medicare Advantage HMO Services Contract ("**Contract**") is January 1, 2024 ("**Effective Date**") by and between Orange County Health Authority, a public agency dba CalOptima ("**CalOptima**"), and Monarch Health Plan, Inc. ("**HMO**"), a California corporation organized under the laws of the State of California. CalOptima and HMO may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima is a County Organized Health System ("**COHS**") organized under Welfare & Institutions Section 14087.54 and Orange County Ordinance No. 3896.

B. CalOptima is licensed as a health care service plan by the California Department of Managed Health Care ("**DMHC**") under the Knox-Keene Health Care Service Plan Act of 1975 and its implementing regulations (collectively the "**Knox-Keene Act**") and authorized to offer a Medicare Advantage ("**MA**") plan pursuant to Title 42 of the United States Code, Chapter 7, Subchapter XVIII, Part C and its implementing regulations for individuals covered under the federal Medicare program.

C. CalOptima, as a dual–eligible special needs plan ("**DSNP**"), may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and the California Department of Health Care Services ("**DHCS**").

D. HMO is licensed as a restricted health care service plan by the DMHC and provides or arranges for the provision of health care services to its assigned enrollees.

E. CalOptima and HMO desire to enter into the Contract whereby HMO will perform delegated administrative services and arrange for or furnish health care items and services as described herein to certain Enrollees enrolled in CalOptima's MA plan and assigned to HMO.

F. Unless defined elsewhere in the Contract, the defined terms used in this Contract shall have the meanings set forth in Attachment A.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, it is agreed by and between the Parties as follows:

I. HMO SERVICE OBLIGATIONS

1.1 **Covered Services**. HMO shall provide Covered Services to Enrollees selecting, and/or assigned to, HMO in accordance with all provisions of this Contract and CalOptima Policies. The Covered Services that are to be provided by and are the financial responsibility of HMO are described in Attachment B. HMO specifically agrees to accept financial risk and responsibility for injectables pursuant to Health & Safety Code Section 1375.8.

1.1.1 HMO shall provide Covered Services: (i) in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients; (ii) in accordance with professionally recognized standards of practice, (iii) in a culturally

Group Name _____
OneCare HMO

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competent manner to all Enrollees, including those with limited English proficiency or reading skills and from diverse cultural and ethnic backgrounds; and (iv) not discriminate in the provision of such Covered Services because of an Enrollee's race, ethnicity, color, national origin, religion, sex, sexual orientation, age, medical or claims history, mental or physical disability, genetic information, or source of payment.

1.1.2 HMO is prohibited from closing or otherwise limiting its acceptance of Enrollees as patients unless the same limitations apply to all of its commercially insured patients.

1.1.3 HMO shall use its best efforts, where consistent with sound medical practice, to ensure that Covered Services are provided only by HMO Physicians and/or other Participating Providers, except in cases of Emergency Services or Urgent Care Services, or if no such HMO Physician or Participating Provider is available to perform the appropriate Covered Services.

1.1.4 HMO shall be liable for the provision and payment of all Covered Services notwithstanding a delay in payment of the Capitation Payment.

1.1.5 HMO acknowledges that the determination of whether a service or supply was/is a Covered Service delegated to HMO rests with CalOptima, subject to the Evidence of Coverage and Appeals procedures established by the DMHC and CMS.

1.1.6 CalOptima may incorporate any change in Covered Services mandated by Laws into the Contract effective the date the change goes into effect. Whenever possible, CalOptima shall give the HMO thirty (30) calendar days' prior notice of any such change to the Contract. CalOptima shall determine the effective date of the change in Covered Services. Attachment B shall not be amended during the current Term without mutual consent of the Parties, except as may be required for continued compliance with Laws.

1.1.7 Decisions concerning whether to provide or authorize Covered Services under this Contract shall be based solely on Medical Necessity. HMO shall not deny Authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary. The actual provision of any Covered Service is subject to the professional judgment of the PCP or other physicians and/or Providers participating with HMO as to the Medical Necessity of the Covered Service, except that each Physician shall provide assessment and evaluation services ordered by a court or legal mandate. HMO acknowledges that disputes between the HMO and Enrollees about Medical Necessity can be appealed pursuant to CalOptima Policies and Laws.

1.1.8 HMO may not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of the diagnosis, type of illness, or condition. HMO may place appropriate limits on a service on the basis of criteria such as Medical Necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose and such a limitation complies with Laws.

1.2 **Confidentiality**. HMO and CalOptima agree to safeguard the confidentiality of Enrollee information and comply with all Laws (including, but limited to, the Health Insurance Portability and Accountability Act ("HIPAA"), 42 CFR Section 431.300 *et seq*., California Welfare and Institutions Code Section 14100.2, California Civil Code Section 56 *et seq.*, and the California Information Practices Act, Civil Code Section 1798) regarding the confidentiality and disclosure of Enrollee names, health, enrollment and personal information (including medical and Behavioral

Health information contained in Medical Records). HMO shall provide counseling to Enrollees on their right to confidentiality and obtain Enrollee consent prior to releasing confidential information unless such consent is not required pursuant to Title 22 CCR Section 51009.

1.3 **Emergency Services and Urgent Care**. HMO shall insure that it provides and pays for all Emergency Services and Urgent Care, including those services provided by Non-Participating Providers, without prior Authorization, twenty-four (24) hours each day, seven (7) days a week, in accordance with Laws and CalOptima Policies. HMO shall coordinate access to Emergency Services in accordance with CalOptima's emergency department protocol. HMO shall ensure adequate follow-up care for those Enrollees who have been screened in the emergency room and require non-Emergency Services. HMO may not specify what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

1.4 **Days to Appointment**. HMO shall ensure that appointments for non-Emergency Services and non-Urgent Care Covered Services are scheduled within ten (10) business days of the Enrollee's request for PCP and fifteen (15) business days of Enrollee's request for Specialist Physician; that health assessments and general physical examinations and all preventative Covered Services are scheduled within thirty (30) calendar days of Enrollee's request for an appointment, and that, if HMO supplies maternity Covered Services, HMO shall ensure that the most current standards and guidelines of the American College of Obstetricians and Gynecologists are utilized as the minimum measure of quality for perinatal services. HMO shall also have a process in place for follow-up on Enrollee missed appointments.

1.5 **Twenty-Four (24) Hour HMO Coverage**. HMO shall ensure that it has, at a minimum, two HMO Physicians as follows: One (1) HMO Physician who is available twenty-four (24) hours a day to authorize Medically Necessary, Post-Stabilization Care Services and coordinate transfer of stabilized Enrollees in an emergency department, if necessary, and one (1) HMO Physician available twenty-four (24) hours a day, seven (7) days a week to resolve disputed requests for Authorizations.

1.6 **Clinical Laboratory Improvement Amendments**. HMO 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.

1.7 **CalOptima Formulary Compliance**. Participating Providers shall comply with the CalOptima Formulary and its associated drug utilization and disease management guidelines and protocols. Requests for items not included in the CalOptima Formulary shall require prior Authorization by CalOptima. The prescribing Physician shall be responsible for obtaining Authorization through CalOptima and/or its designated pharmacy benefit management contractor ("**PBM**"), as appropriate. The prescribing Physician shall provide CalOptima and/or the PBM with all information necessary to process Authorization requests.

1.8 **Enrollee Access**. HMO and its Downstream Entities shall comply with all Laws and CalOptima Policies governing Enrollee access to Covered Services.

1.8.1 If HMO is unable to provide necessary Covered Services to a particular Enrollee, HMO must adequately and timely cover these services with Non-Participating Providers for the Enrollee, for as long as HMO is unable to provide them. HMO shall make prior arrangements with Non-Participating Providers for the provision of such services, shall be fully responsible for arranging and paying for such services, and shall comply with all

applicable CalOptima Policies with regard to the payment and Authorization of Non-Participating Providers.

1.8.2 HMO shall ensure that PCPs as well as Specialty Physicians are located so as to assure sufficient geographic and physical access of Enrollees to such providers as required by Laws and CalOptima Policies.

1.8.3 HMO shall ensure that each Enrollee has a PCP who is available and physically present at the service site for sufficient time to ensure access for the assigned Enrollee when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the PCP in the event of the PCP's vacation, illness, or other unforeseen circumstances.

1.8.4 HMO shall ensure female Enrollees have direct access to a women's health specialist within the network to provide women's routine and preventative health care services. Such access may be in addition to the Enrollee's PCP.

1.8.5 HMO shall cover family planning services for all Enrollees whether they are provided by a Participating Provider or Non-Participating Provider.

1.8.6 HMO shall reasonably accommodate Enrollees and ensure programs and services are as accessible (including a sufficient number of Providers and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities in accordance with CalOptima Policies. HMO's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990 ("**ADA**") and shall ensure access for the disabled, including, but not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provisions. HMO shall have policies to ensure that physical, communication and programmatic barriers do not inhibit Enrollees with disabilities from obtaining all Covered Services, including addressing reasonable accommodations required by the CMS Contract and CalOptima Policies. HMO will comply with CalOptima Policies and work plan requirements related to ADA compliance relevant to services under this Contract.

1.9 **Provider Network Maintenance**. HMO agrees to employ or contract with a sufficient number of Physicians and other Providers representing the range of medical specialties necessary, in the determination of CalOptima, CMS, and the DMHC to ensure Enrollees of reasonable access to the full range of Covered Services.

1.9.1 During the Term, all Participating Providers of Covered Services must: (i) be and remain qualified in accordance with current applicable legal, professional, and technical standards; (ii) be and remain appropriately licensed, certified or registered; (iii) be and remain in good standing with Medicare and not be terminated or suspended from participation in the Medicare and/or Medi-Cal programs; and (v) have a valid NPI number, as applicable. HMO shall ensure that PCPs are located so as to assure sufficient geographic and physical access of Enrollees to such Physicians under Laws and CalOptima Policies.

1.9.2 HMO shall ensure that Participating Providers have the requisite training and experience in dealing with the medical problems frequently encountered in elderly, disabled, and special needs individuals.

1.9.3 HMO shall use primary source verification to confirm the board certification in each clinical specialty area for which the Physician is being credentialed if the Physician lists such board certification on credentialing applications.

1.9.4 HMO acknowledges that the requirements of this Section 1.9 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 HMO to furnish Covered Services to Enrollees.

1.9.5 HMO will maintain accurate records, including records detailing the status, membership, and qualifications of the Participating Providers in the HMO's network.

1.9.6 If a Provider who seeks to become a Participating Provider is denied a contract with HMO or a Participating Provider is suspended or terminated for cause, HMO shall provide the Provider with written notice of the reason for the action, as required by Laws, including any standards and profiling data HMO used to evaluate the provider, the number and mix of similar health care Providers that HMO needs (if applicable), and notice of the Provider's right to appeal the action, including notice of the process and timing to request a hearing. In the event HMO terminates a contract with a Participating Provider for deficiencies in the quality of care provided, HMO shall give notice of the action to CalOptima, as provided by CalOptima Policies, and to the appropriate licensing and disciplinary bodies, as provided by law.

1.9.7 In the event that a Provider, including a PCP, is terminated or leaves the HMO for any reason, HMO shall give written notification of termination of such Provider to CalOptima within fifteen (15) days after receipt or issuance of the termination notice.

1.9.8 In the event that a Provider, including a PCP, is terminated or leaves the HMO for any reason, HMO shall ensure that there is no disruption in services provided to Enrollees who are receiving treatment for a chronic or ongoing medical condition in accordance with applicable Laws.

1.9.9 HMO shall notify CalOptima at least sixty (60) days before any significant change in HMO's provider network that renders HMO unable to provide one or more Covered Services within CalOptima's access to care standards. If such notice is not possible because the providers terminate their participation with less than sixty (60) days' notice or HMO terminates the providers without prior notice as a result of their endangering the health and safety of Enrollees, providers committed criminal or fraudulent acts, or providers engaged in grossly unprofessional conduct, then HMO shall notify CalOptima immediately upon receipt of notice of the termination, or sending notice to the providers of a HMO-initiated termination.

1.9.10 HMO shall ensure that no Provider who fails to meet the requirements of this section furnishes items and/or services to Enrollees, submits claims and/or receives reimbursement for any Covered Services.

1.9.11 HMO agrees that each Participating Provider with whom HMO contracts to provide Covered Services will be required to execute a contract with HMO. Such an agreement will require all Participating Providers to comply with those aspects of this Contract relating to activities of Participating Providers and with Laws, including the standards of accrediting and regulatory agencies governing CalOptima's MA Program, and any and all

provisions required by MA regulations. The HMO agreement with Participating Providers shall be made available to CalOptima and its regulatory agencies for inspection and copying upon request. HMO shall ensure that all contracts with Participating Providers allow for termination of the contract for failure to meet the requirements of this Section 1.9.

1.10 **Enrollment**. HMO shall accept as Enrollees all persons indicated as Enrollees by the CalOptima information system and transmitted to HMO and shall comply with requirements to provide notices to Enrollees in accordance with CalOptima Policies.

1.11 **Primary Care Physician**. HMO agrees that each Enrollee will select or be assigned a PCP. Enrollee must request a PCP assignment from CalOptima's Customer Service department. If the Enrollee has not selected a PCP, CalOptima shall assign the PCP per its policies. HMO agrees that it will ensure that the PCP shall be responsible for the provision, coordination, referral, and Authorization of Covered Services in accordance with the utilization management ("**UM**") program and prevailing standards of medical practice so that there is a Physician who has ultimate responsibility for the Enrollee's care management.

1.12 **HMO Medical Director**. HMO shall designate a HMO Physician as Medical Director for purposes of this Contract. The HMO Medical Director will be a member of the HMO's quality management and UM committee(s) and will be the individual to whom CalOptima communicates regarding provision of professional medical care and quality and/or appropriate utilization of medical services. The HMO Medical Director will be the individual responsible for representing HMO in the resolution of any Grievances presented to CalOptima by Enrollees related to the provision of medical care.

1.13 **Care Coordination**. CalOptima shall retain the responsibility for the initial HRA and an HRA annually thereafter in accordance with CalOptima Policies, but any update during the course of the year due to change in Enrollee's condition/circumstance would be the responsibility of the HMO, per policy. HMO shall offer care coordination and case management services to all Enrollees, which shall: (i) include coordination of care across the full continuum of service providers as appropriate to Covered Services under this Contract; (ii) ensure that care coordination services reflect a person-centered, outcome-based approach, consistent with the Model of Care and CalOptima Policies; (iii) follow Enrollee direction about level of involvement of his or her caregivers or medical providers; (iv) include the assignment of a qualified Care Coordinator to each Enrollee needing or requesting one; and (v) reflect access to appropriate community resources with a focus on providing services in the least restrictive setting and transitions between the facilities and the community.

1.14 **Model of Care**. HMO shall furnish Covered Services in compliance with CalOptima's Model of Care, including the PCC component, HRA, ICP and ICT requirements.

1.14.1 CalOptima will complete and communicate the HRA to HMO. HMO shall, upon notification by CalOptima of the need to follow-up on the results of an HRA administered by CalOptima, perform and provide any follow-up required by CalOptima.

1.14.2 HMO shall develop an ICP for each Enrollee and engage Enrollees and/or their representative in the design of the ICP in accordance with CalOptima Policies.

1.14.3 HMO shall offer an ICT for each Enrollee, as necessary, which will be developed around the Enrollee and integrate medical and LTSS and the coordination of Behavioral Health

services. Enrollees shall not be required to participate in the ICT and may opt-out at any time. Enrollees may not be dis-enrolled from the ICT for lack of participation on the ICT. The ICT shall comply with CalOptima Policies.

1.14.4 PCPs and/or the Care Coordinator, in collaboration with CalOptima, will provide basic case management services to Enrollees in accordance with CalOptima's Policies. If the Enrollee has been identified as potentially benefiting from complex case management services, HMO shall provide such services to the Enrollee.

1.14.5 HMO shall ensure the provision of discharge planning when an Enrollee is admitted to a Hospital or institution and continues into the post-discharge period. Discharge planning shall include ensuring that the necessary care, services, and supports are in place in the community for the Enrollee once he or she is discharged, including scheduling an outpatient appointment and/or conducting follow-up with the Enrollee or caregiver. HMO shall comply with CalOptima Policies addressing minimum criteria requirements for discharge planning.

1.15 **Behavioral Health Services Referrals**. HMO shall furnish and/or coordinate Behavioral Health services as specified in CalOptima Policies and this Contract.

1.15.1 For Specialty Mental Health Services, HMO shall refer Enrollees to CalOptima as the Administrative Service Organization contracted to provide assessment, referral and Authorization services.

1.15.2 For Outpatient Mental Health Services that are within a HMO' PCP's scope of practice, HMO shall manage according to current appropriate treatment guidelines. If the Outpatient Mental Health Services are outside its PCPs' scope of practice, HMO shall refer Enrollees to CalOptima's contracted behavioral health provider.

1.15.3 For Enrollees requiring alcohol or substance use disorder treatment, HMO shall manage according to the appropriate PCP treatment guidelines. If the alcohol or substance use disorder treatment are outside its PCPs' scope of practice, HMO shall refer Enrollees to CalOptima's contracted behavioral health provider. Coordination of care through the ICT will occur as is specified in CalOptima Policies and this Contract.

1.16 **LTSS Referrals**. HMO shall refer Enrollees to CalOptima for LTSS pursuant to CalOptima Policies.

1.17 **Facility Site and Medical Record Reviews**. HMO shall participate in, and comply with requirements for, PCP site and medical reviews, including facility site physical accessibility reviews, in accordance with CalOptima Policies and guidance issued by CalOptima's Regulators, including requirements, if any, related to collaborative programs.

1.18 **Transfers**. HMO agrees to assist CalOptima in facilitating the transfer of care of Enrollees if determined medically acceptable by attending Physicians and the CalOptima Medical Director. HMO will be responsible for the cost of Covered Services provided if HMO refuses to accept such transfer.

1.19 **Delegation by CalOptima to HMO**. HMO agrees to accept delegated responsibility for those activities listed in the Delegation Agreement and to perform the delegated activities in a manner consistent with the Delegation Criteria. HMO warrants that it meets CalOptima's Delegation

Criteria and acknowledges that delegation to another entity does not alter HMO's ultimate obligations and responsibilities set forth in this Contract. HMO agrees to notify CalOptima of any change in its ability to meet the Delegation Criteria within twenty-four (24) hours from the date it fails to meet such Delegation Criteria. At CalOptima's request, HMO shall identify the Compliance Officer or other appropriate health network representative to be the liaison expressly responsible for oversight of delegated obligations.

1.19.1 HMO acknowledges that it is CalOptima's responsibility to oversee, monitor and evaluate HMO's ongoing eligibility for delegation according to the Delegation Criteria and performance of the delegated activities according to the Delegation Criteria. HMO agrees to cooperate with CalOptima's oversight, monitoring, and evaluation of HMO's eligibility and performance of delegated activities, including the provision of reasonable access during regular business hours to the Enrollee inquiry files, credentialing files, clinical and Medical Records of Enrollees, and all other information requested by CalOptima. HMO shall comply with corrective actions imposed by CalOptima and/or CalOptima's Regulators in the time and manner required by them.

1.19.2 HMO acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly delegated herein and in the Delegation Agreement by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

1.19.3 HMO agrees to provide CalOptima with periodic reports on delegated activities performed by HMO as provided in the Delegation Criteria or specified in CalOptima Policies.

1.19.4 In the event CalOptima, DMHC, or CMS is dissatisfied with the performance of delegated functions and activities by HMO or its Downstream Entities, CalOptima may, in its sole discretion, modify HMO's delegated status (in respect to all or a particular delegated activity), including from fully delegated to delegated with corrective action, or may immediately revoke all or part of the delegated activities. In the event HMO breaches its obligation to perform any delegated obligations, CalOptima shall have all remedies set forth in this Contract, including the right to revoke delegation of such function(s) and impose financial and other penalties. Moreover, CalOptima shall have the right to require HMO to terminate any Downstream Entity for good cause, including breach of its obligations to perform any delegated duties. Nothing herein is intended to limit CalOptima's remedies as provided for in this Contract or at law.

1.19.5 HMO acknowledges and agrees that CalOptima, in its sole and absolute discretion, may reduce HMO's Capitation Payments to recoup additional administrative costs where CalOptima revokes or modifies activities or functions delegated to HMO under this Contract.

1.20 **Delegation and Subcontracting of Administrative Services by HMO**. Except as otherwise limited by this Contract and/or CalOptima Policies, HMO may sub-delegate Administrative Services required of HMO to a management services organization ("**MSO**"), medical group and/or IPA. Delegation shall not absolve HMO of oversight responsibilities or its obligations under this Contract. All requests for delegation of Administrative Services (i) must be in writing; (ii) are subject to successful completion of CalOptima's readiness assessment requirements; and (iii) must be approved by CalOptima in advance of undertaking the Administrative Services. HMO shall obtain written approval of delegation from CalOptima pursuant to the process detailed in CalOptima Policies.

1.21 **Subcontracts**. HMO is required to inform CalOptima of the name and business addresses of all subcontracted Downstream Entities. HMO is required to ensure that all such subcontracts are in writing and include all provisions required by this Contract to be incorporated into subcontracts. HMO acknowledges that CalOptima's FDR subcontracts are subject to the review and approval of CMS.

1.22 **Payment to Providers**. CalOptima hereby delegates claims processing functions to HMO. HMO shall review, adjudicate, and pay (as appropriate) all claims in accordance with the benefits set forth in the Evidence of Coverage, the requirements established by Laws, and the terms of this Contract. In making payments to Providers, HMO shall comply with the provisions of Attachment D, including requirements related to payment of Non-Participating Provider Emergency Services and Urgent Care claims.

1.23 **Documentation and Data Submission Integrity**. HMO and its Downstream Entities shall not submit false claims or financial reports, encounter data, and other information to CalOptima, CMS or DMHC, whether by commission or omission. HMO and applicable Downstream Entities shall implement and maintain policies and procedures that address correct completion of claims, financial reports, encounter data, and other documentation requirements and penalties for falsifying such reports and other information that require all new and current employees and/or agents compiling or providing this information to sign a statement of attestation that will acknowledge understanding and compliance with said HMO policy.

1.24 **Advance Directives**. HMO shall maintain written policies and procedures related to Advanced Directives in compliance with Laws. Providers shall document Advance Directives in patient records in accordance with Laws. HMO shall not discriminate against any Enrollee on the basis of that Enrollee's Advance Directive status. Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

1.25 **Enrollee Appeals**. Enrollees will be notified of all applicable MA and/or Medicare Appeal rights, the form and content of which is approved by CMS. . Medicare Appeal rights and protections will be maintained and enhanced for Medicare services. HMO agrees to cooperate with CalOptima in resolving Appeals related to HMO or HMO's Participating Providers and will comply with CalOptima Policies related to Appeals.

1.26 **Organization Determination Process**. HMO agrees to comply with CMS regulations and instructions and CalOptima Policies pertaining to timely organization determination by HMO with regard to the provision, denial, reduction, or suspension of a Covered Service to an Enrollee. "**Organization determination**" is defined as a decision to provide or deny service based on CMS and CalOptima criteria. Such determinations shall be made in accordance with procedures and instructions set forth in the CalOptima Policies and Laws. HMO shall immediately notify CalOptima of any request for an expedited initial organization determination and submit to CalOptima on a monthly basis a report which tracks the requests for standard and expedited organization determinations and the timeframe within which Enrollees were informed of decisions made by HMO.

1.27 **Expedited Review Process**. HMO shall comply with CMS regulations and CalOptima Policies pertaining to expedited initial organization determinations of Enrollee's medical care and reconsideration (Appeals) thereof in the time sensitive situations. Time sensitive situations are those outlined by CMS which include medical conditions that require initial determinations to be

made within seventy-two (72) hours upon HMO receiving a request for an expedited review from a Provider, Enrollee, or CalOptima.

1.28 **Linguistic and Cultural Sensitivity**. HMO shall comply with all requirements related to the provision of linguistic and culturally sensitive services in accordance to this Contract, CalOptima's Cultural and Linguistic Services Program, and CalOptima Policies. HMO shall address the special health needs of Enrollees who are of any minority, are homeless, are disabled (both congenital and acquired disabilities), or are part of other special populations served by the CalOptima MA Program, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those Enrollees who are deaf, hard-of-hearing, and/or visually impaired. Physician shall, in policies, administration, and services, practice the values of: (a) honoring the Enrollees' beliefs, traditions and customs; (b) recognizing individual differences within a culture; (c) creating an open, supportive, and responsive organization in which differences are valued, respected and managed; (d) through cultural diversity training, foster in staff and Participating Providers attitudes and interpersonal communication styles that respect Enrollees' cultural backgrounds and are sensitive to their special needs; and (e) referring Enrollees to linguistically and culturally sensitive programs. Pursuant to CalOptima Policies, HMO shall provide translation of written materials in the Threshold Languages as provided by CalOptima Policies. Written materials to be translated include, but are not limited to, signage, the Enrollee services guide, Enrollee information, Explanation of Coverage, Enrollee forms, Enrollee notices, and Enrollee welcome packages.

1.29 **Provision of Interpreters**. Oral interpreters, signers, and bilingual Provider services shall be provided in all languages spoken by all MA Enrollees. HMO shall provide linguistic interpreter/translator services for Enrollees as necessary at all HMO sites to ensure the availability of effective communication regarding treatment, diagnosis, medical history, and health education to Enrollees. HMO shall provide twenty-four (24)-hour access to interpreter services for all Enrollees. Upon an Enrollee or Participating Provider request for interpreter services in a specific situation where care is needed, HMO shall make all reasonable efforts to provide an interpreter in time to assist adequately with all necessary Covered Services, including Urgent Care Services and Emergency Services, as required by Laws. HMO shall routinely document all such efforts and make this documentation available to CalOptima at its request. Interpreters shall be used where needed where technical, medical, or treatment information is to be discussed. HMO shall not require an Enrollee to use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Enrollee; (ii) will not compromise the effectiveness of service; (iii) will not violate Enrollee's confidentiality; and (iv) the Enrollee is advised that an interpreter is available at no cost to the Enrollee. HMO shall maintain a contract with an interpreter service agency that is on "on call" status to provide interpreter services.

1.30 **Identification of HMO and HMO Physicians**. HMO agrees that CalOptima may list the HMO's name, address, and telephone number and that of its HMO Physicians and Downstream Entities in CalOptima's roster of Participating Providers that is given to Enrollees and prospective Enrollees, and CalOptima may use such names for advertising/marketing purposes. However, CalOptima is not obligated to list the name of any particular HMO Physician in the roster of Participating Providers. The use of HMO's trademarks or logos by CalOptima is prohibited without HMO's prior written approval.

1.31 **Liaisons**. HMO shall designate an individual(s) who will assume the day-to-day responsibilities with regard to HMO's obligations under this Contract and to serve as liaison with CalOptima. HMO will also designate an individual(s) to be responsible for answering Enrollee inquiries and

responding promptly to any Enrollee grievance in accordance with CalOptima's grievance procedures and Laws.

1.32 **Provider Private Contract**. HMO understands that CalOptima is prohibited by CMS from paying capitation to, or including in its provider network, any provider that has entered into a private contract with a Medicare beneficiary for the provision of Covered Services. HMO shall notify CalOptima immediately in the event that any HMO Physician has a private contract with a Medicare beneficiary. In such an event, CalOptima reserves the right to exclude any such HMO Physician from its provider network. In addition, HMO agrees that CalOptima shall have the right to offset the amount of any reimbursement that was paid either directly or indirectly to such Provider(s) against Capitation Payments or other amounts due from CalOptima to HMO, if any.

1.33 **Disclosure of HMO PIPs**. In the event that HMO implements and maintains a physician incentive plan ("**PIP**"), HMO and its Downstream Entities must comply with all applicable requirements governing PIPs, including such requirements appearing at 42 CFR Parts 417, 422, 434, 438.6(h), and 1003.

1.33.1 HMO shall ensure that no specific payment is made directly or indirectly under a PIP to a Physician or HMO as an inducement to reduce or limit Medically Necessary services furnished to an Enrollee.

1.33.2 On an annual basis, HMO and its Downstream Entities must submit to CalOptima all information required to be disclosed to CMS and the DMHC in the manner and format specified by them.

1.33.3 HMO must provide information on its PIP to any Enrollee upon request as provided in 42 CFR Section 422.208.

1.33.4 In the event that CalOptima's Regulators find that HMO (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of federal financial participation ("**FFP**") amounts from CalOptima, HMO agrees that CalOptima may recover such FFP amounts attributable to HMO from HMO, including through recoupment or offset to future Capitation Payments or other amounts due from CalOptima to HMO, if any.

1.34 **Provider Grievance Process**. HMO shall establish and maintain a Provider dispute resolution process that at all times complies with the requirements of Laws. HMO shall provide CalOptima with all necessary information and reports regarding the provider dispute resolution process as required by CalOptima to meet its obligations under the CMS Contract and Laws. If HMO fails to maintain a process that complies with the requirements stated in Laws and CalOptima Policies, then following written notice of such deficiency from CalOptima to HMO, CalOptima may revoke the delegation and assume responsibility for the administration of HMO's Provider dispute resolution process.

1.35 **Provider Education**. HMO acknowledges that CMS requires that CalOptima furnish to Participating Providers certain training, education, and orientation related to the MA Program in order to operate in full compliance with this Contract and Laws. Such training and education may address the MA Program, Enrollee rights, cultural competency and clinical protocols, evidence-based guidelines and cultural awareness and sensitivity instruction. HMO and its Participating

Providers shall participate in such training, education, and orientation programs, as required by CalOptima, and shall attest to compliance with training requirements as required by CalOptima.

1.36 **State Licensure**. HMO shall maintain at all times during the Term a valid, restricted health care service Plan license with the DMHC in accordance with the Knox-Keene Act and have no adverse actions with regard to enforcement or quality management.

1.37 **CalOptima's Regulator Requirements**. The MA Program is subject to oversight by CalOptima's Regulators, which mandate that CalOptima and its FDRs comply with certain terms and conditions in rendering services to Enrollees and that certain terms be incorporated in FDR subcontracts. HMO acknowledges that it will comply with CalOptima's Regulators' requirements set forth in Attachment E.

1.38 **COB Obligations of HMO**. HMO agrees to 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 pursuant to CalOptima Policies. HMO agrees to establish procedures to effectively identify, at the time of service and as part of its claims payment procedures, individuals and services for which there may be a financially responsible party other than the CalOptima MA Program.

1.39 **CMS Lien Rights.** HMO shall coordinate benefits either operating a cost avoidance method of paying claims, when the existence of private health coverage is known at the time the claim is processed, or using the method of post-payment recovery of the cost of services, if the coverage is identified retroactively, as set forth in CalOptima Policies. Nothing herein shall be interpreted to, in any manner, impair any lien rights retained by the U.S. Department of Health and Human Services ("**HHS**") through CMS. HMO shall make no claim for the recovery of the value of Covered Services rendered to an Enrollee when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Enrollee, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. HMO shall identify and notify CalOptima, within five (5) calendar days of discovery of potential third-party liability ("**TPL**") claims, and provide information relative to potential TPL claims, in accordance with CalOptima Policies.

1.40 **Provider Training.** HMO shall ensure that all network Providers receive training regarding the MA Program in order to operate in full compliance with all Laws, including rights and responsibilities pertaining to grievance and appeals procedures and timelines under this Contract. HMO shall ensure that network Provider training relates to MA services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information among network Providers, Enrollees, and/or other healthcare professionals. HMO shall conduct training for all network Providers within thirty (30) working days after the HMO places a newly contracted Provider on active status. HMO shall ensure that network Provider training includes information on all Enrollee rights, including the right to full disclosure of health care information and the right to actively participate in health care decisions. HMO will maintain policies and procedures on advance directives pursuant to 42 CFR §§ 422.128, 438.3(j), and 489.102, and will educate its network Providers concerning its policies and procedures on Advance Directives. HMO shall ensure that ongoing training is conducted when deemed necessary by either the HMO or CMS.

1.41 **Notification of Inpatient Facility Discharge Appeal Rights**. HMO's contracted Hospitals shall issue the advance written notice to Enrollees of their Hospital discharge rights upon admission and before discharge from the Hospital.

II. HMO FINANCIAL OBLIGATIONS

2.1 **Financial Security Requirements**. HMO must establish and maintain during the Term financial security requirements as specified in Article 9 of Chapter 2 of Division 1 of Title 28 of the California Code of Regulations (SB 260 Regulations), and in compliance with CalOptima Policies. HMO 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, as required in CalOptima Policies.

2.2 **Financial Viability Standards and Reporting**. HMO must establish and maintain a minimum reserve of twenty-five percent (25%) of one month's Capitation Payment. Physician shall have thirty (30) days upon receiving notice from CalOptima to cure any deficit. HMO shall maintain a cash-to-claims ratio of no less than 0.75 at all times during the Term. HMO shall substantiate compliance with this requirement by submitting all applicable reports to the DMHC that are required under Title 28 CCR Section 1300.75.4.2.

2.3 **Medical Loss Ratio**. HMO shall ensure that it maintains a minimum acceptable loss ratio (as defined by CalOptima Policies) of eight five percent (85%). HMO shall comply with CalOptima requirements related to limitations on administrative costs, as set forth in CalOptima Policies.

2.4 **Termination of HMO Health Network**. If this Contract terminates or expires for any reason, CalOptima may require that HMO take certain actions and/or CalOptima may take certain actions to ensure that all items and services for which HMO is delegated financial risk under this Contract are reimbursed by HMO, including the following: (i) require HMO to reserve sufficient funds to pay any claims run out; (ii) offset HMO's future Capitation Payments or other amounts due from CalOptima to HMO under this Contract or any other agreement, if any, in order to pay HMO's claims; and/or (iii) withhold or offset HMO's Capitation Payments or other amounts due from CalOptima to HMO, including to pay-for-performance, quality incentives, and shared risk pool surpluses, if any, in order to pay amounts owed by HMO to Providers.

2.5 **Conversion of Health Network Model**. If CalOptima approves a change in the delegated model of HMO at any time during the Term, CalOptima may require additional financial protections as a condition precedent to such approval, including: (i) require HMO to reserve sufficient funds to pay any claims run out related to claims which are the financial responsibility of HMO under the existing delegated relationship; (ii) require HMO to meet additional financial security requirements, including the maintenance of financial deposits; and/or (iii) withhold or offset HMO's Capitation Payments or other amounts due from CalOptima to HMO, including pay-for-performance, quality incentives and shared risk pool surpluses, if any, in order to pay amounts owed by HMO to Providers.

2.6 **Cooperation with DMHC**. HMO shall fully cooperate and comply with the DMHC's review and audit process and permit DMHC to obtain and evaluate supplemental financial information related to HMO, in accordance with Title 28 CCR Section 1300.75.4.7. HMO shall also fully cooperate and participate in DMHC's Corrective Action Plan process, in accordance with Title 28 CCR Section 1300.75.4.8.

III. CALOPTIMA OBLIGATIONS

3.1 **CalOptima Services**. CalOptima agrees to provide certain Enrollee and Administrative Services, including processing Enrollee applications, maintaining eligibility records and a system of

verifying eligibility, processing enrollments and dis-enrollments, responding to Enrollee complaints and grievances, informing Enrollees of CalOptima Policies, providing Enrollees with membership cards and informational material, and informing Enrollees of Health Networks.

3.2 **Enrollment**. CalOptima agrees to process all enrollment applications and ensure that each Enrollee selects or is assigned to Health Networks in accordance with CalOptima Policies. CalOptima reserves the right to assign Enrollees to a Health Networks other than that selected by Enrollee.

3.3 **Model of Care and Health Risk Assessment**. CalOptima shall maintain a Model of Care, as required by CalOptima's Regulators. CalOptima shall ensure that, upon enrollment in the CalOptima MA Program, each Enrollee receives an initial HRA and an HRA annually thereafter in accordance with CalOptima Policies and that results of the HRA are shared with HMO in order to coordinate Enrollee care. HMO is responsible for interim updates to the HRA.

3.4 **Authorization Process**. CalOptima shall provide a written Authorization process for Covered Services pursuant to CalOptima Policies.

3.5 **Enrollee Grievance Process**. CalOptima will inform Enrollees that they may file a grievance through CalOptima or the CMS Ombudsman Program for complaints related to Medicare-covered benefits and services. Enrollees may also file a grievance through 1-800 Medicare.

3.6 **Enrollee Appeals**. Enrollees will be notified of all applicable MA Medicare Appeal rights through a single notice prior approved by CMS.

3.7 **CalOptima Formulary**. CalOptima shall publish and maintain the CalOptima Formulary pursuant to CalOptima Policies.

3.8 **Training and Education**. CalOptima agrees to provide Participating Provider education, training, and orientation in accordance with CMS requirements, including training regarding the CalOptima MA Program, Enrollee rights, clinical protocols, evidence-based practice guidelines, and CalOptima's cultural awareness and sensitivity instruction and cultural competency training, as applicable.

3.9 **Marketing**. HMO acknowledges that CalOptima will be responsible for marketing the CalOptima MA Program to Medicare beneficiaries. HMO acknowledges that it shall not conduct any marketing activities except as expressly approved in advance and in writing by CalOptima.

3.10 **Administration of Funds**. CalOptima will administer the funds and payments called for in this Contract to HMO in accordance with provisions outlined in Article VI.

3.11 **No Refusal to Pay or Contract Based on HMO Communications with Enrollees**. CalOptima will not refuse to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has, in good faith, communicated with or advocated on behalf of one or more of his or her prospective, current, or former patients regarding: (i) the provisions, terms or requirements of CalOptima's health care plans as they relate to the needs of such Provider's Enrollees; or (ii) the method by which such Provider is compensated by CalOptima for Covered Services rendered to the Enrollee.

3.12 **CalOptima Policies**. CalOptima will provide HMO with CalOptima Policies as necessary for Group to provide Covered Services to Enrollees. Those CalOptima Policies shall describe all

benefit plans, including copayments, limitations, and exclusions offered by CalOptima to Enrollees. The Provider Manual will be made available to HMO to disseminate to Physicians.

3.13 **Listing of CalOptima**. CalOptima agrees that HMO may list its name, address, telephone number, and a description of the CalOptima MA Program, along with CalOptima's name, in HMO's promotional materials and advertisements. The use of CalOptima's trademarks and logos by HMO is prohibited without CalOptima's prior written approval.

3.14 **CalOptima Oversight**. CalOptima shall monitor HMO's performance under this Contract on an ongoing basis. CalOptima may conduct regularly scheduled audits as well as an annual evaluation of the delegated functions to determine HMO's continued compliance with the Delegation Criteria. CalOptima may impose corrective action plans on HMO and/or its Downstream Entities, as necessary.

3.15 **CalOptima Accountability**. The delegation of the functions and responsibilities stated in this Contract and the Delegation Agreement does not relieve CalOptima of any of its accountability to CMS and obligations to its Enrollees under Laws. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations to HMO.

3.16 **COB Obligations of CalOptima**. CalOptima will cooperate in providing COB information to HMO by collecting appropriate data from the Enrollee at the point of enrollment and supplying such data to HMO.

3.17 **Enrollee Rights**. CalOptima shall ensure that Enrollee rights are fully respected and observed in accordance with Laws and CalOptima Policies. CalOptima shall notify Enrollees of their rights and protections at least annually and in a manner that accounts for cultural considerations, functional status, and language needs.

3.18 **Enrollee Grievances**. CalOptima retains responsibility for the Enrollee grievance process. HMO will comply with CalOptima Policies related to Enrollee grievances, including timely reporting to CalOptima and resolution of Enrollee grievances. Enrollees may file an internal Enrollee grievance at any time with CalOptima or HMO, including grievances related to reasonable accommodations and access to services under the ADA.

IV. QUALITY IMPROVEMENT PROGRAM AND CREDENTIALING

4.1 **CalOptima's Quality Improvement Program**. HMO shall comply with, and participate in, CalOptima's Quality Improvement Program ("**QIP**"). HMO shall immediately notify CalOptima of those Enrollees and cases that fall within the catastrophic and targeted case management guidelines and shall cooperate with CalOptima's case management program for catastrophic and targeted cases. HMO and its Downstream Entities shall fully cooperate with CalOptima with regard to the HEDIS measurements and HEDIS audits, guideline development, preventive services utilization, disease/risk management, clinical service monitoring, and quality improvement studies and initiatives. HMO shall comply with and accept as final the decisions of the CalOptima QIP and, pending resolution of any dispute through the dispute resolution process, comply with the decisions of the CalOptima Quality Improvement Committee.

4.2 **Quality Improvement Functions – Delegation to HMO**. HMO shall establish, maintain and operate a Quality Improvement ("**QI**") program, in accordance with the delineation of responsibilities in the Delegation Agreement, which shall include preparation of an annual QI

program plan, semi-annual work plan, and annual evaluation of effectiveness of the QI program, and report to CalOptima's QI department using the Health Industry Collaboration Effort Reporting Tool. All of the foregoing elements of the QI program shall be consistent with current industry standards, and meet CMS, National Committee for Quality Assurance ("**NCQA**"), The Joint Commission, and CalOptima QIP requirements.

4.2.1 HMO shall adopt a detailed written QI plan, which shall include: (i) well defined goals and objectives; (ii) a well-defined scope that considers all different types and levels of care and service provided to Enrollees; and (iii) clearly defined accountability and responsibility for the QI program.

4.2.2 The Board of Directors of the HMO or a multi-disciplinary QI committee designated by the Board of Directors of HMO shall oversee the 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 meet at least on a quarterly basis. HMO shall maintain attendance records and meeting minutes related to the QI program. The QI committee shall have adequate representation from all categories of the HMO such as Physicians and non-Physician practitioners.

4.2.3 QI Program activities shall be reported in writing to HMO's Board of Directors at least on a quarterly basis. These reports shall be available to CalOptima upon request.

4.2.4 HMO's QI program shall include involvement and participation in network-wide studies/projects initiated by CalOptima. HMO shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of HEDIS).

4.2.5 HMO shall develop an annual QI work plan, which includes the following: (i) goals, scope, and planned projects for the year; (ii) planned monitoring of identified issues and tracking these issues over time; (iii) planned studies/audits suggested by CalOptima or HMO; and (iv) an annual evaluation of the QI program/plan.

4.2.6 HMO shall have a written procedure for responding to the findings of QI activities, such as collecting data, analyzing results, implementing corrective action plans, and reassessing the same data for improvement.

4.2.7 Requirements for the HMO's QI program shall be established by the HMO's QI committee and requirements may change based on changes in industry standards. CalOptima's QI committee shall notify HMO of any additional changes in QI standards and requirements that shall be incorporated in HMO's QI program. HMO shall not be required to change QI program requirements more frequently than once per year.

4.2.8 HMO shall provide, upon CalOptima's request: (i) summaries of QI Committee meetings; (ii) findings following review of specific cases and other reviews; (iii) Medical Records; (iv) written responses to quality-of-care issues or Enrollee complaints; and/or (v) other information as required by CalOptima.

4.2.9 HMO shall comply with all measurement and improvement projects in the manner required by CMS, including the reporting of HEDIS, Health Outcomes Survey and Consumer Assessment of Healthcare Providers and Services measurement results consistent with

Medicare requirements. HMO shall contribute to all applicable CMS data quality assurance processes.

4.3 **Quality Improvement and Credentialing Program**. CalOptima delegates credentialing requirements to HMO as provided in the Delegation Agreement. HMO agrees to comply with CalOptima Policies regarding credentialing standards. In order to ascertain HMO's continuous compliance with CalOptima standards, CalOptima retains the right to oversee HMO's credentialing processes and to mandate changes thereto.

4.3.1 At least annually, HMO shall provide CalOptima with a written credentialing program for the purpose of review and approval by CalOptima. HMO shall also allow CalOptima, after reasonable prior notice, to conduct an on-site audit and review a sample of physician credentialing files to determine that delegation of the credentialing process is appropriate.

4.3.2 HMO's credentialing program shall comply with the requirements specified in 42 CFR Sections 422.504, 423.505 and 438.214, as applicable, which include requirements addressing selection and retention of providers, credentialing and re-credentialing requirements, and nondiscrimination. HMO's credentialing program shall include procedures used for credentialing and re-credentialing Participating Provider's according to current NCQA standards, in addition to procedures used for reducing, suspending or terminating Participating Provider's participation in the organization for reasons relating to quality of care, competence, professional conduct, or service-related issues; procedures for reporting to appropriate authorities serious quality deficiencies that could result in suspension or termination of a Participating Provider's participation; and procedures for provider appeal, as afforded by HMO's fair hearing plan and corrective actions.

4.3.3 HMO shall make best efforts to notify CalOptima within thirty (30) days of any changes involving the rules, regulations, authorities, and responsibilities of the credentialing program. In accordance with CMS requirements, CalOptima also retains the right, based on quality-of-care and service issues, to approve, suspend, or terminate arrangements with practitioners, providers, and sites. In the event that this occurs, CalOptima will notify the HMO of the quality-of-care and/or service issue, and HMO shall take appropriate action, report to appropriate authorities any serious quality deficiencies in accordance with Laws, and provide all due process as afforded by the HMO's fair hearing plan and Laws.

4.3.4 If CalOptima exercises its right to terminate a Provider's participation in the CalOptima MA program, CalOptima shall give the Provider a written statement of the reason or reasons for termination with cause and comply with the procedures required by Laws, if any.

4.4 **Release of Performance Information and Data**. HMO acknowledges that the CalOptima MA Program focuses on improving the coordination and quality of medical, Behavioral Health, LTSS, and other services for Enrollees, and, in that regard, CalOptima's Regulators will implement capitation withholds to ensure performance consistent with established quality thresholds. HMO acknowledges and agrees that CalOptima may release information and data related to the performance of HMO under this Contract to CalOptima Regulators, Providers, Enrollees, and others without further notice to HMO. The performance data will be used for purposes, including quality improvement activities, and public reporting to consumers, as identified in CalOptima Policies.

V. UTILIZATION MANAGEMENT PROGRAM

5.1 **CalOptima's Utilization Management Program**. CalOptima has implemented, and continuously updates, a UM program to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered Services to Enrollees in the timeframes required by CalOptima's Regulators. HMO and its Downstream Entities shall comply with and cooperate in CalOptima's UM program, as established in CalOptima Policies and the CalOptima UM plan, regardless of CalOptima's delegation to HMO under Section 5.2.

5.2 **UM Program Responsibility—Delegation to HMO**. CalOptima is hereby delegating to HMO the process of monitoring and evaluating on a prospective, concurrent, and retrospective basis, the utilization and Medical Necessity of Covered Services provided to HMO's Enrollees.

5.2.1 HMO's UM process shall include performing case management activities, referral management and discharge planning, and managing the denial sanction process, as well as conducting peer review for Medical Necessity and appropriateness. HMO (and its Downstream Entities) shall ensure that its UM program complies with all criteria as set forth in CalOptima Policies and required by CalOptima's Regulators.

5.2.2 In accordance with 42 CFR §§ 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities must not be structured so as to provide incentives for HMO (including HMO Physicians) or Downstream Entities to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee.

5.2.3 In the event HMO (or its Downstream Entities) fails to comply with CalOptima standards and Laws and fails to correct deficiencies within the stated time required by those provisions, CalOptima retains the right to revoke delegation of UM activities.

5.3 **Utilization Management Plan**. HMO will provide to CalOptima initially upon execution of this Contract, and annually thereafter, a written UM plan for review and approval by CalOptima.

5.3.1 HMO shall notify CalOptima within thirty (30) days of any changes involving the rules, regulations, authorities, and responsibilities for the UM plan, which shall be subject to reasonable approval by CalOptima. CalOptima approval will be assumed unless HMO is notified otherwise by CalOptima. HMO shall comply with and accept as final, the decisions of CalOptima's UM program and, pending resolution of any dispute through the dispute resolution process, comply with the decisions of CalOptima's UM program.

5.3.2 The UM plan shall include procedures approved by CalOptima to identify, assess, establish, and implement a treatment plan for Enrollees with complex or serious medical conditions. The UM plan shall also contain procedures for direct access of Enrollees to services as mandated by CMS regulations and instructions. All HMO denial letters shall provide Enrollees with timely notice and shall contain appropriate Enrollee appeals rights as approved by CMS and CalOptima. HMO agrees to cooperate with CalOptima in furnishing the required reports identified in CalOptima' Policies

5.4 **Utilization Management Committee**. HMO shall establish a UM committee that shall review and document the quality, appropriateness, level of care, and utilization of health care services provided to Enrollees. CalOptima's Medical Director and/or CalOptima staff may attend HMO UM committee meetings.

5.5 **Process and Timeframes for Authorization**. HMO (and its Downstream Entities) shall ensure that its process for initial and continuing Authorizations complies with CalOptima Policies, the UM plan and requirements established by CalOptima's Regulators, including timeframes for, and manner of, Authorization.

5.6 **No Prior Authorization**. HMO (and its Downstream Entities) shall not require prior Authorization for the following services: (i) any services for Emergency Medical Conditions (which include emergency Behavioral Health care); (ii) Urgent Care sought outside the Service Area: (iii) Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the Participating Provider is unavailable or inaccessible; (iv) preventative services; (v) family planning services; (vi) Out-of-Area renal dialysis services; (vii) basic prenatal care; (viii) sexually transmitted disease services; and (ix) HIV testing.

5.7 **Second Opinions**. HMO (and Downstream Entities) shall ensure that Enrollees have the right to second opinions from qualified health professionals at no cost to the Enrollee.

5.8 **Physician Direct Referral**. HMO agrees that an Enrollee shall, without obtaining the prior Authorization of the PCP or HMO, refer him or herself directly to a specialist within said HMO per policy including any of the following conditions: an annual well woman exam by a Gynecologist, prenatal care and delivery by an Obstetrician, annual eye exam by an Optometrist, professional services related to audiology, and family planning services, including but not limited to vasectomy.

5.8.1 CalOptima will identify HMO as a provider that offers HMO Direct Referrals to Enrollees in CalOptima's provider directory and other marketing literature, if any. In the event CalOptima determines that HMO is non-compliant with the requirements of the Physician Direct Referral process, CalOptima reserves the right, at its sole discretion, to cease marketing HMO as a Physician Direct Referral provider to Enrollees.

5.8.2 HMO agrees to cooperate with CalOptima and, upon reasonable prior notice, provide CalOptima with all necessary Medical Records, policies and procedures, including utilization review, reports, and other pertinent information that may be necessary or required to enable CalOptima to ensure and verify that HMO has a Physician Direct Referral process acceptable to and in accordance with the requirements of CalOptima.

5.9 **Hospital Referrals**. HMO agrees to require HMO Physicians to admit Enrollees only to a Participating Provider Hospital with the concurrence of CalOptima, except for Emergency Services, Urgent Care, or when Authorization has been received in accordance with the UM Plan.

5.10 **Personal Care Coordinator Component to the Model of Care.**

5.10.1 "**PCC Profile**" is a monthly report generated by CalOptima that provides the compliance parameters required to receive PCC supplemental capitation.

5.10.2 HMO shall employ PCCs and participate in all PCC component requirements, as defined in the Model of Care Profile. PCCs shall assist Enrollees in the development of an ICP, ensure communication of the Enrollee's care plan with the Enrollee, physicians, HMO and health care team, and provide other related services as described in the job description, CalOptima Policy, and Model of Care Profile. HMO shall submit monthly reports and ICPs to demonstrate adherence to Model of Care requirements, including staffing of PCCs.

5.10.3 CalOptima may amend the Model of Care Profile at any time and, in such event, CalOptima shall provide HMO with thirty (30) days' written notice before the effective date of any such revisions. If HMO is unable to agree to the revisions and no resolution is reached in the thirty (30)-day period, HMO may proceed with the termination of the Contract under Article 11. In the event HMO terminates the Contract, it shall comply with all of its obligations required by this Contract and Laws including obligations related to transfer and coordination of Enrollee care following termination.

VI. COMPENSATION

6.1 **HMO Compensation**. CalOptima shall compensate HMO for Covered Services and Administrative Services delegated to HMO, as set forth in Attachment C. Such Capitation Payments shall be payment in full for Covered Services and Administrative Services, except for amounts recovered through collection of Enrollee's Share of Cost, COBs, and Stop Loss Program, if applicable. Capitation Payment shall be sent on a monthly basis by the twentieth (20th) calendar day of the month, or if such day falls on a weekend or national holiday, on the first business day thereafter, for all Enrollees eligible from the first (1st) of the month, and on whose behalf payment has been received by CalOptima from CMS by the nineteenth (19th) calendar day of the month. In the event CalOptima receives payment from CMS after the nineteenth (19th) calendar day of the month, capitation payment to HMO will be made within five (5) working days of receipt of the monthly payment by CalOptima.

6.2 **Disputes Regarding Payments or Enrollment**. Any and all disputes related to Capitation Payments and/or enrollments shall be reported to CalOptima within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance of the Capitation Payment by HMO.

6.3 **Capitation Rate Adjustments**. The Capitation Rates may be adjusted by CalOptima during the Contract period to reflect implementation of State or federal laws or regulations, changes in the CMS Contract or CMS policy, and/or changes in Covered Services. If CalOptima receives advance notice of adjustment from CalOptima's Regulators, CalOptima shall provide notice thereof to HMO as soon as practicable. Capitation Rates may also be adjusted in the event of de-delegation of any function delegated under this Contract.

6.4 **Enrollee Non-Liability and Hold Harmless Requirements.** HMO and its Downstream Entities shall accept CalOptima's payment as described in this Contract as payment in full. HMO and its Downstream Entities for all Covered Services and Administrative Services under this Contract and shall not hold Enrollees liable to the HMO or Providers for any sums owed to HMO by CalOptima or owed to Providers by HMO.

6.4.1 HMO and its Downstream Entities shall hold harmless CMS, CalOptima, and Enrollees in the event HMO and/or Downstream Entities cannot or will not pay for services performed by HMO or Downstream Entities pursuant to this Contract or subcontract, as applicable.

6.4.2 HMO and its Downstream Entities shall ensure that Enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the HMO will (i) accept Capitation Payment as payment in full under the Contract, or (ii) bill the appropriate State source, as required at 42 CFR §422.504(g)(1)(iii). Such services must be provided at zero cost-sharing to Enrollees.

6.4.3 HMO shall not hold an Enrollee liable for the following: (i) debts of HMO, in the event of 'HMO's insolvency; (ii) Covered Services provided to the Enrollee in the event that CalOptima or HMO fails to receive payment from CMS for such services; or (iii) payments to a clinical FDR or Downstream Entity in excess of the amount that would be owed by the Enrollee if HMO had directly provided the services.

6.4.4 HMO and its Downstream Entities shall not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise permitted under this Contract.

6.4.5 HMO and its Downstream Entities shall not deny any service provided under this Contract to an Enrollee for Enrollee's (or any entity responsible for making payment on Enrollee's behalf) failure or inability to pay any applicable charge or shall not deny any service provided under this Contract to an Enrollee who, prior to becoming eligible, incurred a bill that has not been paid.

6.5 **Overpayments Discovered by Physician Group**. HMO shall disclose and return all overpayments to CalOptima within sixty (60) days of when HMO identified the overpayment or should have identified the overpayment through the exercise of reasonable diligence.

6.6 **Recoupment for Ineligibility; Conlan Reimbursements**. CalOptima shall recoup payments made to HMO when CMS has determined that an individual was not eligible for the MA Program and retroactively terminates the individual, including recouping any payments made for a deceased Enrollee. CalOptima may also recoup overpayments to HMO owed by HMO to Enrollees, including offsetting any such amounts owed against HMO's Capitation Payments or other amounts due from CalOptima to HMO under this Contract or any other agreement between the parties, if any. This Section 6.6 shall not be construed to limit CalOptima's right to recoup payment made to HMO on any other basis for which recoupment is appropriate.

6.7 **CalOptima Right to Recover**.

6.7.1 Overpayments. HMO acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to HMO, CalOptima shall have the right to recover such amounts from HMO by recoupment or offset from current or future amounts due from CalOptima to HMO under this Contract or any other agreement between the parties, after giving HMO notice and an opportunity to return/pay such amounts.

6.7.2 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 HMO paid by CalOptima against any funds owed to HMO by CalOptima, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

6.7.3 Regulator Recoupment Upon Termination. If following the termination or expiration of this Contract, CalOptima's Regulators find that HMO (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of FFP, as described in Section 1.33, CalOptima may elect to recoup such FFP amounts, as allowed by Laws, by either: (1) offsetting such FFP amounts, upon notice to HMO, from any current or future amounts owed by CalOptima to HMO under the Contract or any other agreement between the Parties, including capitation payments, financial

security withholds, pay-for-performance amounts, quality incentives, or shared risk pool surpluses; or (2) sending an invoice to HMO that payment for such FFP amounts are due to CalOptima within thirty (30) days of HMO's receipt of the CalOptima invoice.

6.7.4 Dispute Resolution. HMO may use CalOptima's provider dispute resolution procedure, as described under CalOptima's Policies, and/or the dispute resolution procedures under this Contract to resolve any disputes related to the calculation or payment of such Deficits or FFP amounts.

6.7.5 Survival. This Section 6.7 shall survive the termination or expiration of the Contract."

6.8 **Retroactive Cancellation**. CalOptima will discourage retroactive cancellation of any Enrollee. However, CalOptima may make exceptions as required by CMS or due to legitimate administrative processing requirements of CMS. CalOptima may make retroactive additions or cancellations of Enrollees, as necessary for administrative or business reasons, and such retroactive additions or cancellations of Enrollees shall not exceed ninety (90) days.

VII. REPORTING REQUIREMENTS

7.1 **Data Reporting Requirements**. HMO shall comply with the data reporting requirements set forth in this Contract, including the requirements specified in Standard Reporting Requirements set forth in CalOptima Policies and guidelines (referred to as the Timely and Appropriate Submission requirements). HMO shall provide such additional data and modify the form, content, instructions, and timetables for the collection and reporting of data, as may be required by CalOptima Policies.

7.2 **Eligibility Reports**. CalOptima will maintain, update, and distribute monthly Enrollee eligibility reports for each month in which the persons included on such list are eligible for CalOptima MA Program. This report will identify the HMO, PCP selected by the Enrollee, and the Enrollee's coverage. The report will be sent to HMO and PCPs by the tenth (10th) of each month, identifying eligible Enrollees from the first (1st) of the month.

7.3 **Utilization Data**. HMO shall, upon request, provide CalOptima with information on the utilization and cost of Covered Services provided to Enrollees in such detail as to allow CalOptima to conduct analysis of costs as required by CMS, as dictated by sound business practices and for the conduct of quality management and UM activities by CalOptima. Such information to be provided by HMO will not include information beyond that customarily provided on a claim form (such as Form CMS-1500) and shall be provided in the form of a paper report, computer disc, computer tape, or electronic file, as agreed by the parties. Required data will be delivered by HMO to CalOptima not later than forty-five (45) days following written request by CalOptima.

7.4 **Submission of Electronic Encounter Data**. HMO must meet any claims, diagnosis, and Encounter Data reporting requirements, as determined from time to time by CalOptima and CalOptima's Regulators.

7.4.1 HMO agrees to furnish CalOptima with complete, timely, reasonable, and accurate Encounter Data for Covered Services rendered to Enrollees. The Encounter Data will be furnished to CalOptima through Electronic Data Interchange (EDI) or a mutually acceptable format and shall be received by CalOptima per the Policy and Encounter Requirements Manual. HMO also agrees to furnish Medical Records that may be required to obtain any additional information or corroborate the Encounter Data. HMO further

agrees to have its Chief Executive Officer (CEO) attest and certify the completeness and truthfulness of the Encounter Data submitted.

7.4.2 HMO shall be subject to financial penalties and/or sanctions if CalOptima determines that Physician is reporting to CalOptima less than all professional encounters in the CalOptima required format and timelines. Financial penalties or sanctions shall be assessed upon HMO should CalOptima determine that HMO is not meeting the standards defined in CalOptima Policies. This Section 7.4.2 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. Based on CalOptima's quarterly determinations and following thirty (30) days' prior notice to HMO, CalOptima may withhold three (3%) percent of Capitation Payment if CalOptima determines that the monthly Encounter Data that HMO must provide has not been received by CalOptima within the prior quarter. If at the quarterly determination following such withhold, CalOptima determines that HMO has satisfactorily delivered to CalOptima the previously non-delivered Encounter Data; such withheld Capitation Payment shall be paid to HMO, without interest. In the event that HMO does not deliver such Encounter Data to CalOptima prior to such quarterly determination, CalOptima shall be entitled to retain such withheld Capitation Payment and may withhold three (3%) percent from each quarter's Capitation Payment until CalOptima receives the Encounter Data.

7.5 **Financial Reporting**. HMO shall prepare financial information requested in accordance with Generally Accepted Accounting Principles ("**GAAP**"). Where financial statements and projections are requested by CalOptima and/or CalOptima's Regulators, these statements and projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Act rules found under Title 28 CCR Section 1300.51 *et. seq*. Information submitted shall be based on HMO's current operations. HMO shall submit financial information consistent with filing requirements of the DMHC, unless otherwise specified by CMS.

7.6 **Financial Statements**. CalOptima, as a Knox-Keene Act health care service plan, is required by CalOptima's Regulators to monitor the financial viability of its contracted provider network on an on-going basis. HMO agrees to provide CalOptima annually with a copy of HMO's audited financial statements, including letters to management for the most recent fiscal year end along with an opinion letter on these statements from the accounting firm that completed an audit on these financial statements. Financial statements shall be presented in a form specified by CalOptima that clearly shows the financial position of HMO as related to Enrollees. HMO shall allow representatives of CalOptima, upon written request, to verify the financial reports. In the event audited statements are unavailable, HMO agrees to provide CalOptima with the unaudited financial statements at HMO's fiscal year end. The unaudited financial statements will include: balance sheets, income statement and statement of cash flows, notes to the financial statement, name of the person preparing these statements, and representation letters from the senior financial executives of the HMO, attesting that these financial statements were prepared in accordance with GAAP and fairly present the financial condition of the HMO.

7.7 **Reports Regarding Disclosure of Confidential Enrollee Information**. If HMO, or any of its officers, employees, agents, or Downstream Entities, becomes aware of the unauthorized disclosure of confidential Enrollee information or of "personal information", within the meaning of California Civil Code Section 1798.3, HMO shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this section, "unauthorized disclosure"

includes any unauthorized access, whether such access was through inadvertence, mistake, theft, or other means, and whether or not HMO had reasonable control to avoid the disclosure. Nothing herein is intended to limit or replace HMO's separate obligations under the Business Associate Agreement and Laws.

7.8 **Additional Information Required by CalOptima's Regulators**. HMO and Downstream Entities shall, at the request of CalOptima or CalOptima's Regulators, provide the following: (i) all information related to the performance of CalOptima's responsibilities, including non-medical information for the purposes of research and evaluation, to CalOptima's Regulators; (ii) any information required to comply with all Laws; and (iii) any information required for external rapid cycle evaluation, including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee complaints and Appeals, and enrollment/disenrollment rates.

VIII. RECORD RETENTION, ACCESS AND CONFIDENTIALITY

8.1 **Disclosure of Records**. HMO and its Downstream Entities agree to maintain and make available contracts, books, documents, records, and electronic systems, including, Medical Records, (collectively, the "**Records**") to CalOptima, HHS, CMS, the Comptroller General, the U.S. Government Accountability Office, any Quality Improvement Organization, or accrediting organizations, including NCQA, their designees, and other representatives of regulatory or accrediting organizations, for inspection, evaluation, and auditing. For purposes of utilization management, quality improvement, and other CalOptima administrative purposes, CalOptima and CalOptima's Regulators shall have access to, and copies of, at reasonable time upon request, the Medical Records, books, charts, and papers relating to the provision of health care services to Enrollees, the cost of such services, and payments received by HMO or any of HMO Physicians from Enrollees (or from others on their behalf). Copies of the Medical Record shall be provided at no charge to CalOptima. Unless a longer time is required under applicable law, the records described herein shall be maintained for at least ten (10) years from the final date of the Contract or from the completion of any audit, whichever is later.

8.2 **Medical Records**. HMO will require that all HMO Physicians and Downstream Entities establish and maintain in an accurate and timely manner, for each Enrollee who has obtained Covered Services from a Group Provider or Downstream Entity, a legible Medical Record which shall be kept in detail consistent with good medical and professional practice in accordance with Laws and CalOptima Policies. Such Medical Records shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the 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 Enrollee's medical problem and the services provided and permit peer review of the care provided. HMO shall ensure that medical information is released in accordance with applicable Laws, or pursuant to valid court orders or subpoenas, subject to compliance with applicable privacy laws. HMO shall ensure than an individual is delegated the responsibility of securing and maintaining Medical Records at each HMO or Downstream Entity site.

8.3 **Right to Inspection**. Medical Records referred to in Section 8.2 above will be and remain the property of HMO or HMO Physicians and will not be removed or transferred from their offices except in accordance with Laws. CalOptima or its designated representatives will have the right, in accordance with this Article 8, to inspect, review, and make copies of such records at HMO's expense upon request to facilitate CalOptima's obligation to conduct quality management, utilization monitoring, and peer review activities.

8.4 **Records Related to Recovery for Litigation**. Upon request by CalOptima, HMO and its Downstream Entities 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 HMO's or its Downstream Entities' possession, relating to threatened or pending litigation by or against CalOptima, HHS, and CMS. If HMO asserts that any requested documents are covered by a privilege, HMO shall: (1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (2) state the privilege being claimed that supports withholding production of the document. Such request shall include a response to a request for documents submitted by any party in any litigation by or against CalOptima. HMO acknowledges that time may be of the essence in responding to such request. HMO shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records received by HMO or its Downstream Entities related to this Contract or subcontracts entered into under this Contract.

8.5 **State and Federal Site Visits**. HMO agrees to permit CalOptima, the DMHC, HHS, and/or CMS to conduct a site evaluation of HMO and its facilities in accordance with Laws and to comply with the agencies' recommendations, if any.

8.6 **Enrollee Access to Records**. HMO (including HMO Providers) and its Downstream Entities shall ensure that Enrollees have access to their Medical Records in accordance with the requirements of Laws. An Enrollee shall be provided a copy of his or her Medical Records, upon request, and shall have the right to request corrections or amendments to their Medical Records as specified in 45 CFR Part 164. HMO and Downstream Entities shall furnish a copy of the Enrollee's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Participating Provider, at no cost to CalOptima or the Enrollee when (i) such a transfer of Medical Records facilitates the continuity of that Enrollee's care; (ii) the Enrollee is transferring from one Provider to another for treatment; and (iii) an Enrollee seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

IX. INSURANCE AND LIABILITY

9.1 **Indemnification**. Each Party agrees to defend, indemnify, and the other Party and the State and CMS harmless, with respect to any and all claims, costs, damages, and expenses, including reasonable attorney's fees, that are related to or arise out of the negligent or willful performance or non-performance by the indemnifying Party, or any functions, duties, or obligations of such Party. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release either Party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion. CalOptima and HMO agree to promptly notify the other Party of any claims or demands that arise and for which indemnification hereunder is sought.

9.2 **Insurance Requirements**.

9.2.1 **HMO Liability Insurance**. HMO agrees to procure and maintain, at its own expense, the insurance policies required by this Section 9.2 and Laws and shall require its Downstream Entities to maintain similar policies of insurance where HMO's insurance does not cover its Downstream Entities. The coverage programs in this Section 9.2 above shall insure the HMO, HMO Physicians and their employees against any claim for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the

performance of, or the failure to perform any service provided by HMO Physicians, their employees or agents.

9.2.2 **Professional/Medical Malpractice**. Each HMO Physician and Participating Provider providing Covered Services to Enrollees shall maintain a professional liability (medical malpractice) insurance policy for the specialty or type of service that the HMO Physician provides with minimum limits of one million dollars ($1,000,000) per incident and three million dollars ($3,000,000) in the aggregate per Physician per year for all Physicians who are partners, associates or employees of HMO. HMO warrants that all Physicians that it contracts with for the provision of Covered Services will carry professional liability coverage in the same amount and that each Hospital providing Covered Services to Members shall maintain a professional liability insurance policy with a minimum of five million dollars ($5,000,000) per incident/five million dollars ($5,000,000) in the aggregate per year. If HMO, HMO Physicians, or its Downstream Entities have a claims-made malpractice insurance policy, they agree to keep the policy in effect for at least seven (7) years past any termination of the Contract or purchase "tail" coverage. Said "tail" coverage shall have the same policy limits as the primary professional liability policy.

9.2.3 **Commercial General Liability/Commercial Automobile Liability**. HMO and each Participating Provider who has entered into a contract with HMO to provide Covered Services under this Contract shall maintain a Commercial General Liability insurance policy and a Commercial Automobile Liability insurance policy with minimum limits as follows:

- Commercial General Liability: One million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate.

- Commercial Automobile Liability: One million, two hundred thousand dollars ($1,200,000) combined single limit for bodily injury or property damage covering any automobile, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent.

CalOptima must be named as an additional insured on Comprehensive General Liability and Commercial Automobile Liability insurance policies with respect to performance under this Contract.

9.2.4 **Workers' Compensation**. HMO Physician and each Participating Provider who has entered into a contract with HMO to provide Covered Services under this Contract shall maintain a Workers' Compensation Insurance policy that provides statutory coverage with minimum limits as follows:

- Employers' Liability Insurance:
  - One million dollars ($1,000,000) Bodily Injury by Accident - each accident.
  - One million dollars ($1,000,000) Bodily Injury by Disease - policy limit
  - One million dollars ($1,000,000) Bodily Injury by Disease - each employee

9.2.5 **Managed Care Errors and Omissions**. HMO shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

- Managed Care Errors and Omissions: Ten million dollars ($5,000,000) each claim/ten million dollars ($5,000,000) aggregate

9.2.6 **Electronic and Computer Crimes Insurance**. HMO and its Downstream Entities shall maintain electronic and computer crimes insurance and employee fidelity insurance with limits of at least one million dollars ($1,000,000) if HMO and/or its Downstream Entities will be paying claims or receiving funds on behalf of CalOptima, or will be storing, transmitting, and/or receiving personally identifiable and/or protected health information on a regular basis in carrying out its obligations under this Contract..

9.2.7 **Insurer Ratings**. Insurance required under this Article IX shall be provided by an insurer:

(a) Rated by A.M. Best with a rating of A V or better; and

(b) "Admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) An Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7

9.2.8 **Captive Risk Retention Group/Self Insured**. Where any of the insurance(s) mentioned in this Article IX 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.

9.2.9 **Cancellation or Material Change**. HMO shall not of its own initiative cause such insurance as addressed in this Article IX to be cancelled or materially changed during the Term.

9.2.10 **Proof of Insurance**. Certificates of Insurance of the insurance policies and/or evidence of self-insurance required under this Article IX shall be provided to CalOptima prior to Effective Date, annually thereafter, and upon request.

X. COOPERATION

10.1 **Non-Interference**. HMO and Downstream Entities may not prohibit of otherwise restrict a health care professional, acting within the lawful scope of practice, from freely communicating with Enrollees about their treatment and the following, regardless of benefit coverage limitations:

10.1.1 The Enrollee's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the Enrollee to decide among all relevant treatment options;

10.1.2 The risks, benefits, and consequences of treatment or non-treatment; or

10.1.3 The opportunity for the Enrollee to refuse treatment and to express preferences about future treatment decisions.

10.2 **No Counseling to Dis-enroll**. HMO and HMO Physicians agree that they will not, during the Term, provide advice to or counsel any Enrollee to dis-enroll from CalOptima, and HMO and HMO Physicians will not solicit such Enrollee to become enrolled with any other health maintenance organization, preferred provider organization, or any other similar hospitalization, medical payment plan or insurance program.

10.3 **Cooperation**. CalOptima and HMO agree that, to the extent compatible with the separate and independent management of each, they will at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits to Enrollees at the most reasonable cost, consistent with quality standards of hospital and physician care.

10.4 **Signs**. HMO agrees that CalOptima may post notices, mutually acceptable as to size, content and form in a prominent place instructing Enrollees as to proper procedures and limitations on coverage.

10.5 **Free Exchange of Information**. No provision of this Contract shall be construed to prohibit, nor shall any provision in any contract between HMO and its employees or Downstream Entities, prohibit, the free, open, and unrestricted exchange of any and all information of any kind between Providers and Enrollees regarding the nature of the Enrollee's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under the Enrollee's Evidence of Coverage, and the Enrollee's right to appeal any adverse decision made by HMO or CalOptima regarding coverage of treatment which has been recommended or rendered. HMO and CalOptima agree not to penalize nor sanction any Provider in any way for engaging in such free, open, and unrestricted communication with an Enrollee nor for advocating for a particular service on an Enrollee's behalf.

XI. TERM AND TERMINATION

11.1 **Term of Contract**. The term of this Contract shall become effective on the Effective Date and continue in effect for five (5) years through _____ ("Initial Term") and five (5) additional one-year automatic extensions except as directed otherwise by the Board.

11.2 **Sanctions and Terminations for Cause**. If HMO fails to fulfill any of its duties and obligations under this Contract, including: (i) committing acts to discriminate against Enrollees; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the HMO by Enrollees whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's compliance and fraud, waste and abuse programs; (vi) failing to meet financial requirements in Article II; (vii) committing fraud, waste or abuse relating to Covered Services or any and all obligations, duties, and responsibilities under this Contract; (viii) failure to enforce claims payment prohibitions on HMO Physicians who are denied the right to submit claims and/or receive reimbursement for services furnished to Enrollees; (ix) failure of HMO Physicians to comply with pharmacy requirements as determined by CalOptima; (x) failure to submit Encounter Data or comply with other reporting requirements pursuant to this Contract and CalOptima Policies; and/or (xi) failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, CalOptima may take any one or more of the actions described in this Article XI.

11.3 **Corrective Action Plans**. CalOptima may require a Corrective Action Plan ("**CAP**") in the event that any report, audit, survey, site review or investigation indicates that the HMO or any Downstream Entity is not in compliance with any provision of this Contract.

11.3.1 A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the HMO or any Downstream Entities. CalOptima shall issue a written notice of deficiency and shall require that a CAP to be submitted within thirty (30) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP depending upon the nature of the deficiency.

11.3.2 Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the HMO is not in compliance with the provisions of this Contract, CalOptima Policies, and minimum performance requirements as established by CalOptima. All monetary fines are payable to CalOptima within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to CalOptima for any monetary fines within the thirty (30) calendar day period shall result in CalOptima deducting the penalty plus administrative fees from the HMO's Capitation Payment.

11.4 **CalOptima Termination for Cause**. Notwithstanding and in addition to any other provisions of this Contract, CalOptima may terminate this Contract for cause effective upon thirty (30) calendar days' written notice; cause shall include, but shall not be limited to, the actions set forth in Section 11.2. CalOptima's rights and remedies provided in this provision shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

11.5 **HMO Termination for Cause**. HMO may terminate this Contract for cause only upon thirty (30) calendar days' written notice and only in the event that CalOptima fails to make payments due under this Contract within fifteen (15) calendar days of when such amounts are due and payable.

11.6 **Immediate Terminations**. In addition to all other sanction and termination rights, CalOptima may terminate Contract immediately upon delivery of written notice to HMO if:

11.6.1 HMO (including HMO Physicians) and/or its Downstream Entities are unable to secure the necessary governmental licenses, approvals, and/or certificates required for the performance of their duties;

11.6.2 CalOptima determines that the health, safety, or welfare of Enrollees is jeopardized by continuation of this Contract;

11.6.3 HMO commits fraud, waste, or abuse; or

11.6.4 CMS fails to authorize or reauthorize CalOptima to operate a MA Program for a period that overlaps the Term.

11.7 **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) calendar days' prior to the effective date of such termination.

11.8 **Bankruptcy**. If during the Term there is filed by or against HMO in any court pursuant to any statute of the United States or any state, a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee or conservator of all or a portion of HMO's assets,

or if HMO makes an assignment for the benefit of creditors, or if HMO becomes unable, admits in writing its inability, or fails generally to pay its debts as they become due, this Contract may, at the option of CalOptima, be canceled and terminated. In the event of the filing of a petition for bankruptcy by or against HMO, HMO shall assure that all of HMO's functions and duties related to the Contract are performed in accordance with the terms of the Contract. CalOptima shall have the right to withhold any and all amounts otherwise due to HMO until HMO fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining any and all withheld amounts as necessary to ensure that all HMO obligations have been met.

11.9 **Termination of CMS Contract.** In the event the CMS Contract with CalOptima is terminated or not renewed, the provisions of this Contract shall automatically terminate unless otherwise specified by CalOptima and subject to any provisions that survive termination. Any term provided in the Contract is subject to CMS's continuing approval of CalOptima's MA Program. HMO agrees to assist CalOptima with such transfer of care requirements mandated by CMS in the event of termination of the CMS Contract.

11.10 **Continuation of Benefits**. HMO and its Participating Providers agree that, in the event of CalOptima's insolvency or cessation of operations, benefits to Enrollees will continue through the period for which capitation has been paid or until the discharge of Enrollee from an inpatient facility, whichever time is greater. Covered Services to an Enrollee confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their appropriate discharge.

11.11 **HMO Obligations Following Termination**. In the event of termination of this Contract, at CalOptima's sole option, HMO will continue to provide Covered Services, and CalOptima shall reimburse for such services per the Medicare fee schedule, to Enrollees until CalOptima has made arrangements with alternative Providers to render care to Enrollees. HMO shall cooperate and assist CalOptima in the transfer of Enrollee care in the event this Contract or any relevant Downstream Entity subcontract is terminated for any reason. HMO shall provide a plan for the orderly termination of services under this Contract, in form and substance acceptable to CalOptima.

11.12 **Prohibition on Use of Certain HMO Physicians**. HMO agrees that CalOptima reserves the right to require HMO, upon notification from CalOptima, to prohibit any HMO Physician or Downstream Entity from providing services, whether Covered Services or otherwise, to Enrollees when CalOptima deems such prohibition to be in the best interests of the Enrollees, provided that imposition of the foregoing prohibition shall not terminate this Contract.

XII. GENERAL PROVISIONS

12.1 **Dispute Resolution**.

12.1.1 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 12.1.2.

12.1.2 Arbitration. If the parties are unable to resolve any dispute arising out of or relating to this Contract under Section 12.1.1, 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.

12.1.3 Exclusive Remedy. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 12.1.2 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.

12.1.4 Waiver. By agreeing to binding arbitration as set forth in Section 14.19.2, the parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

12.2 **Interpretation of Contract Language**. CalOptima has the right to final interpretation of the Contract language when disputes arise. HMO has the right to appeal disputes concerning Contract language to CalOptima.

12.3 **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.

12.4 **Assignment**. This Contract and the rights, interests, duties, and obligations hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by HMO nor shall the duties and obligations imposed herein be subcontracted or delegated without the prior written consent of CalOptima, which consent may be withheld in CalOptima's sole and absolute discretion for any reason or no reason. HMO acknowledges and agrees that CalOptima's consent, if any, to assignment and/or delegation is subject to the approval of CMS. Therefore, any assignment and/or delegation of this Contract, including the rights, interests, duties, and obligations hereunder, shall be void unless prior written consent is obtained from CalOptima and CMS. HMO further acknowledges and agrees that CalOptima may require HMO and the proposed assignee/sub-

delegate to cooperate in due diligence and sub-delegation assessment activities as part of its review of any request for consent to assignment of this Contract and the rights, interests, duties, and obligations hereunder. HMO agrees to cooperate and provide such information as requested by CalOptima. HMO acknowledges and agrees that (i) CalOptima's due diligence and/or assessment activities related to any proposed assignment may take one hundred eighty (180) days or more; (ii) in no event shall CalOptima's due diligence and/or delegation assessment activities be construed as CalOptima's consent to assignment; and (iii) any consent to assignment by CalOptima must be reflected in a separate writing executed by CalOptima and other relevant parties. CalOptima may, from time to time, establish policies and procedures regarding its processes for initiating review and approval of any proposed assignment of this Contract. For purposes hereof, the term "**assignment**" shall include any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in HMO (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of HMO; (iii) the merger, reorganization, or consolidation of HMO with another entity with respect to which Physician is not the surviving entity; and/or (iv) a change in the management of HMO from management by persons appointed, elected, or otherwise selected by the governing body of HMO (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

12.5 **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, or employees shall act as nor be construed to be the agent, the employee, or the representative of the other Party.

12.6 **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.

12.7 **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.

12.8 **Amendment**. CalOptima may amend this Contract immediately upon written notice to HMO in the event such amendment is required in order to maintain compliance with Laws. CalOptima may deem all other amendments to the Contract effective after at least forty-five (45) business days' notice or earlier if agreed to by HMO. All amendments of this Contract are subject to CMS approval.

12.9 **No Waiver of Immunity or Privilege**. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged, or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

12.10 **Choice of Law; Jurisdiction and Venue**. This Contract shall be governed by and construed in accordance with all State and federal laws and regulations governing the CMS Contract. The Parties consent to the jurisdiction of the California Courts with venue in Orange County California.

12.11 **Force Majeure**. Either Party, upon prompt written notice to the other Party, shall be excused from performance hereunder for any period that it is prevented from meeting the terms of this Contract

as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes ("**Force Majeure Event**");

12.12 **No Liability of County of Orange**. As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the HMO hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

12.13 **Confidential and Proprietary Information**. HMO agrees to maintain confidential the following information (the "**Confidential Information**"): (a) eligibility lists and any other information containing the names, addresses and telephone numbers of CalOptima Enrollees; (b) CalOptima's administrative service manuals and all forms related thereto; (c) the financial arrangements between CalOptima and any Participating Provider; and (d) any other information compiled or created by CalOptima that is proprietary to CalOptima and that CalOptima identifies as proprietary to HMO in writing. HMO 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. HMO 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 of this Contract, HMO shall promptly return to CalOptima the Confidential Information in its possession, upon CalOptima's notice.

12.14 **Third Party Beneficiaries**. 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.

12.15 **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 6.2, 6.5, 7.8, Article 8, 9.1, 11.10, 11.11, 12.1, 12.2, 12.3, 12.5, 12.6, 12.7, 12.9, 12.10, 12.12, 12.13, 12.14, and any other sections that, by their terms, are intended to survive termination of the Contract.

12.16 **Recitals and Exhibits**. The recitals and exhibits set forth in this Contract are made a part of the Contract by this reference.

12.1 **Without Limitation**. Any reference in the Contract to "include(s)" or "including" means inclusion without limitation, unless otherwise distinguished within the text.

12.2 **Notices**. All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the Party to whom notice is given, or seventy-two (72) hours after mailing by electronic mail transmission, United States priority mail, United States mail first class (Certified Mail or Registered Mail), addressed to the Party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima

Attention: Chief Operating Officer
505 City Parkway West
Orange, California 92868

To: HMO

XIII. CONDITIONS PRECEDENT TO CONTRACT COMMENCEMENT

13.1 **Contract Effectiveness**. The Contract is subject to CalOptima's determination, in its sole discretion, that the following conditions have been met prior to the Effective Date: (i) HMO has successfully met all criteria in CalOptima's readiness assessment, including financial viability and delegated function criteria; HMO has signed CalOptima's Business Associate Agreement; and (iii) HMO has furnished all required documentation and data requested by CalOptima (e.g., insurance documents, licenses).

13.2 **Additional CalOptima Regulator Requirements**. CalOptima, in its sole discretion, may condition this Contract upon HMO's ability to meet other criteria imposed by CalOptima Regulators.

XIV. SIGNATURES

SUBJECT TO (I) THE UNITED STATES GOVERNMENT PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES WITH RESPECT TO WHICH IT IS ENTERED INTO; AND (II) THE APPROVAL OF THIS CONTRACT BY DMHC AND CMS, THIS CONTRACT SHALL BECOME EFFECTIVE ON THE EFFECTIVE DATE AND SHALL TERMINATE ON AS PROVIDED IN THIS CONTRACT.

IN WITNESS WHEREOF, CalOptima and HMO have executed this Contract as indicated below.

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operations Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT A
DEFINITIONS

1. "**Administrative Services**" means those non-clinical, administrative functions that are the responsibility of the HMO as set forth under the Contract and in CalOptima Policies.

2. "**Advance Directive**" means an individual's 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 his or her health care wishes known.

3. "**Appeals**" means an Enrollee's actions, both internal and external to CalOptima, requesting review of the denial, reduction, or termination of benefits or services from CalOptima.

4. "**Authorization/Authorized**" means the approval of CalOptima, or its delegate (which may include HMO), for the provision or referral of Covered Services, obtained in accordance with, and as further described in, the Provider Manual and this Contract.

5. "**Behavioral Health**" means the mental health services and substance use disorder services arranged for or provided to Enrollees by a separate Mental Health Plan, CalOptima, or their subcontractors.

6. "**CalOptima Formulary**" means the CalOptima Approved Drug List, the Disposable Medical Equipment/Supplies List, the CalOptima OneCare Formulary, and any additional formularies as may be designated by CalOptima and provided to CalOptima's designated pharmacy benefits manager "**PBM**". There is no applicable CalOptima Formulary for the PACE program.

7. "**CalOptima Policies**" means CalOptima policies and procedures, including CalOptima's Provider Manual, that are amended from time to time at the sole discretion of CalOptima and incorporated into this Agreement by this reference.

8. "**CalOptima's Regulators**" means those government agencies that regulate and oversee CalOptima's and its FDRs' activities and obligations under this Contract including the Department of Health and Human Services, CMS, and the DMHC and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract, as well as their respective agents and contractors quality improvement organizations.

9. "**Capitation Payment**" means the monthly payment paid to HMO by CalOptima for delivery for Covered Services to Enrollees, which is determined by multiplying the applicable Capitation Rate by HMO's monthly enrollment.

10. "**Capitation Rate**" means the rate set by CalOptima for the delivery of Covered Services to an Enrollee.

11. "**Care Coordinator**" means a clinician or other trained individual employed by or contracted with HMO who is accountable for providing care coordination services for Enrollees, as required by CalOptima Policies and who services on one or more ICTs.

12. "**C.C.R.**" means the California Code of Regulations.

13. "**C.F.R.**" means the Code of Federal Regulations.

14. "**CMS**" means the Center for Medicare & Medicaid Services.

15. "**CMS Contract**" means the agreement between CMS and CalOptima under which CalOptima can establish its MA Program for Enrollees.

16. "**COB**" refers to the coordination of benefits and determination of order of financial responsibility that applies when two or more health benefit plans provide coverage of items and services for an individual.

17. "**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 applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("**FWA**") plan.

18. "**Covered Services**" means those health care items, drugs, and services that an Enrollee is entitled to receive pursuant to a Program applicable to that Enrollee. Covered Services must generally be referred and Authorized in confirming with CalOptima's Policies, including its utilization management program."

19. "**Delegation**" means the process by which CalOptima expressly grants, by formal written agreement to another entity, the authority to carry out a function that would otherwise be required to be performed by CalOptima in order to meet its obligations under the CMS Contract.

20. "**Delegation Agreement**" means the formal written agreement by which CalOptima grants to another entity the authority to carry out a function that would otherwise be required to be performed by CalOptima to meet its obligations under the CMS Contract.

21. "**Delegation Criteria**" means those criteria adopted by CalOptima, for the delegation of activities in the areas of UM, medical records audits, the Office Site Review, 'Enrollee's rights and responsibilities, and credentialing, as set forth in CalOptima Policies.

22. "**DMHC**" means the California Department of Managed Health Care.

23. "**Downstream Entity**" means all Providers and other persons or entities with which HMO has entered into a written subcontract (acceptable to CMS) to perform administrative functions and/or health care services to satisfy HMO's obligations to CalOptima under this Contract, continuing down to the ultimate provider of services. The term "HMO" as used in the terms of this Contract shall also include its subcontractors when such subcontractors are Downstream Entities, even if not expressly referenced in the particular provision.

24. "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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 with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

25. "**Emergency Services**" means those covered inpatient and outpatient services that are (i) furnished by a Provider qualified to furnish Emergency Services; and (ii) needed to evaluate and/or stabilize an Enrollee's Emergency Medical Condition.

26. "**Encounter Data**" means the record of an Enrollee receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators.

27. "**Enrollee**" means an eligible individual who is enrolled in the CalOptima MA Program.

28. "**Evidence of Coverage**" means the document approved by CalOptima's Regulators and issued by CalOptima to Enrollees that describes Enrollee's benefits under the CalOptima MA Program.

29. "**FDR**" means a party that enters into a written agreement (acceptable to CMS) to provide administrative or health care services to CalOptima and/or its Enrollees that are governed by the CMS Contract.

30. "**FQHC**" means an entity that meets all of the requirements for designation as a federally qualified health center under § 1861(aa)(3) of the Social Security Act and is approved for participation in the MA program.

31. "**Grievance**" means an oral or written expression of dissatisfaction, including any compliant, dispute, request for reconsideration, or appeal, made by an Enrollee.

32. "**Health Network**" means HMO, a physician-hospital consortium, or health care service plan (such as an HMO) that is contracted with CalOptima to provide items and services to Enrollees on a capitated basis.

33. "**HMO Physician**" means a Physician who is employed by or under contract with HMO to provide physician services.

34. "**HEDIS**" means the set of standardized performance measures sponsored and maintained by the NCQA.

35. "**HRA**" means the health risk assessment tool that identifies an Enrollee's primary, acute, LTSS, Behavioral Health, and functional needs.

36. "**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005, and regulations promulgated thereunder by the U.S. Department of Health and Human Services, including Title 45 of the C.F.R, Parts 160 and 164.

37. "**Hospital(s)**" means licensed acute care hospital(s) that have entered into an agreement with CalOptima or HMO to provide services to Enrollees in the CalOptima program and where HMO customarily admits patients.

38. "**ICP**" means the plan of care developed by an Enrollee and/or his/her ICT or CalOptima.

39. "**Indian Enrollee**" means an Enrollee who is an Indian (as defined in the Indian Health Care Improvement Act of 1976 [25 U.S.C. §§ 1603(13), 1603 (13 and 23), or 1679(a)] or who has been determined as an Indian under 42 C.F.R. § 136.12.

40. "**Indian Health Care Provider**" means a health care program operated by the Indian Health Services or by an Indian Tribe, Tribal Organization, or Urban Indian Organization, as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

41. "**ICT**" means an interdisciplinary care team comprised of the primary care provider and Care Coordinator and other Providers at the discretion of the Enrollee that work with the Enrollee to develop, implement, and maintain the ICP.

42. "**Laws**" means any local, State, or federal statute, regulation, rule, or executive or agency order applicable to this Contract.

43. "**LTSS**" means the range of long-term services and supports that help Enrollees meet their daily needs for assistance and improve the quality of their lives and which include: (i) In-Home Supportive Services ("**IHSS**"); (ii) Community-Based Adult Services ("**CBAS**"); (iii) Multi-purpose Senior Services Program ("**MSSP**") services; and (iv) skilled nursing facility services and sub-acute care services.

44. "**Medically Necessary**" or "**Medical Necessity**" means when addressing Covered Services: (i) under Medicare, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. Section 1395y.

45. "**Medical Record**" means any record kept or required to be kept by any Provider that documents medical services received by the Enrollee, including inpatient, outpatient, emergency care, referral requests, and Authorizations in accordance with applicable laws including Title 28 C.C.R. § 1300.80(b), Title 42 U.S.C. § 1396a(w), 42 C.F.R. § 456.111 and 42 C.F.R. § 456.211 and CalOptima Policies.

46. "**Mental Health Plan**" means the entity that has contracted with DHCS to provide Specialty Mental Health Services to individuals, including Enrollees.

47. "**Model of Care**" means the component of CalOptima's quality improvement framework that is evidence-based, includes certain clinical and non-clinical elements, and is in addition to the comprehensive care coordination requirements specified in CalOptima Policies.

48. "**Non-Covered Services**" means those services that are not benefits under the CalOptima MA Program in accordance with CalOptima's Evidence of Coverage and applicable state and federal laws and regulations.

49. "**Non-Participating Provider**" means an institution, professional, or other Provider of health care services who has not entered into an agreement, either with CalOptima or HMO, to provide medical and other services to Enrollees.

50. "**Out-of-Area**" means that area that is outside the Service Area.

51. "**Outpatient Mental Health Services**" means outpatient services that are provided to Enrollees with mild to moderate mental health conditions including: (i) individual/group mental health evaluation and treatment (psychotherapy); (ii) psychological testing when clinically indicated to evaluate a mental health condition; (iii) outpatient services for the purpose of monitoring drug therapy; (iv) psychiatric consultation for mediation management; and (v) outpatient laboratory supplies and supplements.

52. "**Participating Provider**" means an institution, professional, or other provider of health care services who has entered into an agreement, either with CalOptima or HMO, to provide health care services to Enrollees.

53. "**PCC**" means the personal care coordinator(s) employed by HMO to comply with the CalOptima MOC Program.

54. "**PCC Component to the Model of Care Profile**" means the PCC Components identified in the Model of Care Profile.

55. **"Physician"** means a person with an unrestricted license to practice medicine or osteopathy in the state in which they practice.

56. "**Physician Direct Referral**" means the process whereby a PCP has the authority the decide whether a referral is deemed necessary for an Enrollee and if deemed necessary the PCP will directly refer that Enrollee within said HMO to any of the specialties or services specified in CalOptima Policies without requiring the prior Authorization of HMO.

57. "**Post-Stabilization Care Services**" means services related to an Emergency Medical Condition that are provided after an Enrollee is Stabilized in order to maintain the Stabilized condition, or under some circumstances, to improve or resolve the condition.

58. "**Preclusion List**" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for MA items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

59. "**PCP**" means a primary care physician responsible for supervising, coordinating, and providing initial and primary care to Enrollees; for serving as the medical home; for processing initial referrals for Specialist Physician care; and for maintaining the continuity of patient care.

60. "**Program**" is health care benefit program offered by CalOptima to Enrollees. Programs and their designs are subject to change periodically.

61. "**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.

62. "**Provider Manual**" means that comprehensive online document, as amended from time to time, and describes CalOptima's Policies and procedures affecting HMO Physicians' services under this Contract.

63. "**Referral**" means the process by which the Participating Provider Physician directs an Enrollee to seek and obtain Covered Services from a health professional or for care at a facility.

64. "**Rural Health Clinic (RHC)**" means an entity that meets all of the requirements for designation as a rural health clinic under § 1861(aa)(1) of the Social Security Act and is approved for participation in the MA program.

65. "**Service Area**" means the geographic area within Orange County, California.

66. "**Shared Risk Services**" will mean those Covered Services that are the financial responsibility under the Hospital Budget, as set forth in Attachment B.

67. "**Specialist Physician**" means any physician who is not a PCP, has the requisite training and education, and meets all other requirements set by CalOptima Policies for specialists.

68. "**Stabilize**" or "**Stabilized**" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure within reasonable medical probability that no material deterioration of the condition is likely to result 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 placenta.

69. "**Threshold Language"** means those languages as determined by CalOptima's Regulators from time to time and identified in guidance on translation requirements provided to CalOptima.

70. "**Urgent Care**" means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury and are medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition but that are the result of an unforeseen illness, injury or condition for which medical services are immediately required.

ATTACHMENT B
CALOPTIMA SENIOR PLAN
MATRIX OF FINANCIAL RESPONSIBILITY
January 1, 2024

HMO	RESPONSIBLE PARTY		
SERVICES	**GROUP**	**HOSPPITAL**	**PLAN**
Medicare Part A Services – Not Otherwise Assigned Herein or in Any Agreement Incorporating This Exhibit:			
Inpatient		**X**	
Outpatient		**X**	
Medicare Part B Services Not Otherwise Assigned Herein or in Any Agreement Incorporating This Exhibit	**X**		
Some of the main services and those related to the Risk Sharing Program are listed below:			
Acupuncture (Medicare covered)	**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	**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**	

SERVICES	GROUP	HOSPPITAL	PLAN
Chemical Dependency Rehabilitation and Detox (Medicare Covered)			
Professional Component	**X**		
Facility Component		**X**	
Methadone outpatient clinics			**X**
Chemotherapy			
Drugs – Outpatient (Part B)		**X**	
Drugs – Outpatient (Part D)			**Rx**
Professional Component	**X**		
Facility Component		**X**	
Chiropractic (Medicare covered)	**X**		
Dental Services (Medical)			
Professional Component	**X**		
Facility Component		**X**	
Facility Component (Non-Hospital) Based	**X**		
Diabetic Supplies			
Insulin and syringes (Rx Benefit)-see Medication-Outpatient Prescription Drug Benefit			**Rx**
Home Glucose Monitoring Equipment and Supplies)	**X**		
Diagnostic Testing			
Technical Component (Outpatient)	**X**		
Professional Component	**X**		
Durable Medical Equipment (DME)			
Outpatient	**X**		
Emergency Room			
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**	

SERVICES	GROUP	HOSPPITAL	PLAN
Professional Component	X		
Genetic Testing/Counseling	X		
Health Education	X		
Hemodialysis/Dialysis			
Outpatient (Includes drugs per Medicare guidelines)		X	
Professional Component	X		
Home Health Care			
Medicare covered home health services (Including home IV therapy, excluding Part D drugs)		X	
Home Health Supplies (see medical supplies)		X	
Hospice	**Medicare FFS has primary responsibility**		
Hospitalization			
Facility Component (Including pre-admission diagnostic services)		X	
Interpretive Reports	X		
Professional Component (Including hospital-based physicians)	X		
Immunization and Inoculations (Part B)	X		
Immunization and Inoculations (Part D)			**Rx**
Infusion Therapy			
Professional Component	X		
Facility Component		X	
Part B drugs		X	
Part D drugs			**Rx**
Injectables -- (Outpatient) (see also Chemotherapy)			
Part B drugs		X	
Part D drugs			**Rx**
Lithotripsy			
Professional Component	X		
Facility Component		X	
Mammography	X		
Maternity/Obstetrics			
Facility Component		X	
Professional Component	X		
Medical supplies (includes catheters)			

SERVICES	GROUP	HOSPPITAL	PLAN
Outpatient	**X**		
Medication			
Outpatient – Prescription Drug Benefit (Part D)			**Rx**
Outpatient medications (Part B)		**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 (Medicare Covered)	**X**		
Parenteral Nutrients, Supplies, Kits and Pumps			
Part B		**X**	
Part D			**X**
Enteral Nutrients, Supplies, Kits and Pumps			
Outpatient			**X**
Organ Transplants			
Pre Evaluation (All Inclusive)	**X**		
Organ Acquisition		**X**	**Medicare FFS for Kidney only**
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 (Medicare defined coverage applies)		**X**	
Ostomy Supplies			
Outpatient	**X**		

SERVICES	GROUP	HOSPPITAL	PLAN
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 (Medicare covered)	X		
Radiation Therapy			
Professional	X		
Facility, outpatient facility		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		
Social Services – Medical	X		
Surgically Implanted Devices – All Categories		X	
Vision Care			
Annual routine exam			X
Glasses			X
Lenses and Frames incidental to cataract surgery (Medicare covered)	X		
Screening, Physician Office	X		

SERVICES	GROUP	HOSPPITAL	PLAN
Notes:			
1. Financial responsibility is based on Medicare 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 C
CAPITATION RATES AND RISK SHARING

1. **Capitation Allocation**

1.1 **Allocation of Non-Part D CMS Revenue**. Each month, CalOptima shall allocate both the non-Part D related capitation that CalOptima receives from CMS for Enrollees affiliated with HMO and any applicable premiums that CalOptima charges Enrollees affiliated with HMO (collectively, the "**Total Revenues**") as follows:

Facility and Other Services ("**Hospital Budget**")	46.4%
Physician Group Capitation Fees	34.1%
Total paid to HMO	80.5%

1.2 **MLR**. In accordance with Section 2.3, "Medical Loss Ratio", of the Contract, HMO shall maintain a minimum acceptable loss ratio of eighty-five percent (85%). Should HMO not meet the minimum eighty-five percent (85%) MLR, CalOptima reserves the right to require HMO to return to CalOptima the difference between eighty-five percent (85%) of Capitation Payments and the allowed medical expenses.

1.3 **Personal Care Coordinator**.

1.3.1 In addition to the amounts described above, and contingent on CalOptima Board of Directors' approval, CalOptima will pay HMO, [redacted] dollars and [redacted] cents ($[redacted]), a per Enrollee, per month amount for PCCs. The commencement date, amount, and duration of such PCC capitation payments, if any, will be established by the action of the CalOptima Board of Directors, and will be deemed incorporated herein by reference. Such payments, if any, may be adjusted in accordance with the PCC Reference Manual and are subject to recovery, termination, or offset as provided in this Contract and in the PCC Reference Manual.

1.3.2 HMO acknowledges and agrees that CalOptima may adjust and/or terminate the PCC Capitation Payments in the event HMO fails to comply with the requirements outlined in the PCC component of the model of care (MOC) profile. HMO acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset HMO's future PCC Capitation Payments in the event CalOptima determines that HMO has not complied with the requirements set forth in the PCC component of the MOC Profile.

1.4 **Pay-for-Performance Program**. CalOptima will develop a pay-for performance program to provide incentive payments to HMO. Payments will be calculated and paid quarterly and annually based on a per Enrollee, per month rate and reflect achievement of specified program goals, which are determined by CalOptima in its sole discretion.

1.5 **Sequestration.** If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to HMO, reduce payment to HMO under this Attachment C by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the Term.

ATTACHMENT D
CLAIMS PROCESSING AND COMPLIANCE OBLIGATIONS

XV. DEFINITIONS

15.1 "**Clean Claim**" means one that can be processed without obtaining additional information from the provider of the service or from a third party. Clean claim shall have the same meaning as "complete claim" as that term is defined in Title 28, CCR Section 1300.71(a)(2). Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

15.2 "**Unclean Claim**" means any claim other than as defined in Section 1.1 of this attachment.

15.3 "**Denied Claim**" means a claim where (a) one or more services will not be paid by HMO and (b) payment is the responsibility of the Enrollee. Examples of claims that are not denials and should not be reported, submitted, or presented to CalOptima as Denied Claims include claims:

15.3.1 For patients who remain enrolled with CalOptima but have transferred to another HMO and HMO is forwarding the claim,

15.3.2 For which payment responsibility belongs to another contracting entity, and HMO is forwarding the claim,

15.3.3 That are duplicates,

15.3.4 That are encounter only/capitated claims and no patient liability is involved, and

15.3.5 That involve reduced payment amounts due to contract terms or allowed Medicare fee schedules.

XVI. GENERAL TERMS

16.1 **HMO Claims Processing**. HMO shall process claims for Provider services according to all CMS requirements and, as applicable, in accordance with the requirements of the Knox-Keene Act. This Attachment D is intended to comply with all DMHC and CMS standards and requirements. Should this Attachment D be out of compliance with any existing or newly enacted DMHC or CMS standard or requirement, the DMHC and/or CMS standard or requirement will supersede this Attachment D. CalOptima will communicate any changes in requirements to HMO in writing.

16.2 If HMO enters into a contract with a Downstream Entity whereby the responsibility for claims processing is delegated to that Downstream Entity, Attachment D provisions shall apply. HMO will have contractual provisions to ensure such Downstream Entity conforms to all DMHC and CMS requirements and oversight provisions as outlined herein and in CalOptima Policies.

16.3 HMO and any applicable Downstream Entity shall be required to have an oversight program for claims processing that includes written policies and procedures, a process for reporting fraudulent or unethical conduct, and an executive accountable for review of claims data and attesting to its accuracy. The oversight program shall include internal auditing of claims functions, and self-reporting as outlined in CalOptima Policies.

XVII. CLAIMS PROCESSING

17.1 **Timely Provider Payments**.

17.1.1 HMO and Downstream Entities, if, and as applicable, must make timely payments to Participating Providers consistent with 42 CFR § 447.45.

17.1.2 HMO shall reimburse Clean Claims, or any portion of any Clean Claim, for Covered Services, as soon as practical, but no later than thirty (30) calendar days after receipt of the claim by HMO, unless the claim or portion thereof is reasonably contested, in which case the claimant shall be notified in writing that the claim is contested or denied within forty-five (45) business days after receipt of the claim by HMO in accordance with CalOptima Policies.

17.1.3 HMO must ensure that ninety percent (90%) of claims from Providers who are in individual or group practice, which can be processed without obtaining additional information from the Provider or from a third party, will be paid within thirty (30) days of the date of receipt of the claim.

17.1.4 HMO must ensure that ninety-nine percent (99%) of all Clean Claims from Providers for Covered Services will be paid within ninety (90) days of the date of receipt of the claim.

17.1.5 Generally, the date of receipt is the date the HMO receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

3.1.6 **"30-Day" Claim Timeliness**. HMO shall adjudicate nine-five percent (95%) of all Clean Claims from Non-Participating Providers or suppliers within thirty (30) calendar days of receiving the claim. Adjudicate a claim shall be deemed to mean to have processed the claim (paid or denied) and mailed the remittance advice by the thirtieth (30^{th}) calendar day since the earliest receipt by HMO or CalOptima's contracting Providers or Hospitals.

17.1.7 **"60-Day" Claim Timeliness**. HMO shall pay or deny Unclean Claims from Non-Participating Providers or suppliers, claims from Participating Providers or suppliers, and claims from Medicare fiscal intermediaries and carriers within sixty (60) calendar days of receipt of such claims. Processing shall be deemed to mean either to have paid or denied and mailed the remittance advice by the sixtieth (60^{th}) calendar day since the earliest receipt by HMO or CalOptima's contracting Providers or Hospitals, or to have denied the claim, and have mailed the denial letter to the Enrollee by the sixtieth (60^{th}) day. In accordance with federal law and CMS regulations, failure to process such claims within sixty (60) calendar days of receipt automatically constitutes an "adverse" initial determination, which the Enrollee may appeal; thus, a denial notice must be mailed to the Enrollee.

17.1.8 **Payment Accuracy**. When paying Non-Participating Providers, HMO shall employ only those Medicare fee schedules that MA plans are allowed to use by law and shall comply with 42 CFR § 422.214.

17.1.9 **Denied Claims**. Decisions to deny claims that result in liability for the Enrollee must be made in accordance with CMS guidelines. Whenever such decisions are made, the currently CMS approved Notice of Denial of Payment or Integrated Denial Notice must be used, including approved denial reasons. Under no circumstances shall HMO deny a claim for the second time as a consequence of responding to a request for reconsideration from an Enrollee; instead, HMO must direct the Enrollee to submit the request directly to

CalOptima as appropriate.

17.2 **Claims for Emergency and Post-Stabilization Services.**

17.2.1 HMO shall not retroactively deny a claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition, turned out to be non-emergency in nature. HMO shall ensure that its claims processing actions do not conflict with Hospital actions required to comply with the Emergency Medical Treatment and Active Labor Act ("**EMTALA**").

17.2.2 If there is a disagreement between HMO or any Participating Provider and any Non-Participating Provider regarding Medically Necessity of Covered Services in an emergency, the judgment of the attending physician(s) actually caring for the Enrollee at the treating facility shall prevail. HMO may establish relationships with treating facility whereby the HMO may send a Participating Provider with privileges to assume the attending physician's responsibilities to establish treatment or may arrange to have a Participating Provider under contract with HMO agree to accept the transfer of the Enrollee after the Enrollee has been Stabilized.

3.2.3 HMO shall ensure that an enrollee with an Emergency Medical Condition will be seen on an emergency basis and that Emergency Services will be available and accessible within the Service Area twenty-four (24) hours a day. HMO shall cover Emergency Services without prior Authorization pursuant to Title 28 CCR Section 1300.67(g), Title 22 CCR Section 53216, and Section 1932(b)(2) of the Social Security Act. HMO shall coordinate access to Emergency Services in accordance with 42 CFR § 438.114 and the HMO's emergency department protocol.

3.2.4 HMO may not refuse to cover Emergency Services based on the emergency room Provider, Hospital, or fiscal agent not notifying the Enrollee's PCP managed care organization, prepaid ambulatory health plan, prepaid inpatient health plan or applicable State entity of the Enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or Stabilize the Enrollee.

3.2.5 HMO may not deny payment for treatment obtained under either of the following circumstances: an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an Emergency Medical Condition; or the HMO representative instructs the Enrollee to seek Emergency Services. The attending emergency Physician, or the Provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently Stabilized for transfer or discharge, and that determination is binding on the entities as responsible for coverage and payment.

3.2.6 HMO must cover and pay for Post-Stabilization Care Services. HMO is financially responsible for Post-Stabilization Care Services obtained within or outside the organization that are pre-approved by a HMO Provider or other HMO representative. HMO is financially responsible for Post-Stabilization Care Services obtained within or outside the HMO organization that are not pre-approved by a Participating Provider or other HMO representative, but are administered to maintain the Enrollee's Stabilized condition within one (1) hour of a request to the HMO for pre-approval of further Post-Stabilization Care

Services. HMO is financially responsible for Post-Stabilization Care Services obtained from within or outside the HMO that are not pre-approved by a Participating Provider or other HMO representative, but administered to maintain, improve, or resolve the Enrollee's Stabilized condition if the HMO: does not respond to a request for pre-approval within one (1) hour; cannot be contacted; or the HMO representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Participating Provider is not available for consultation. In this situation, the HMO must give the treating Physician the opportunity to consult with a Participating Provider and the treating Physician may continue with care of the Enrollee until a Participating Provider is reached or one criteria in 42 C.F.R. § 113(c)(3) is met. HMO must limit charges to Enrollees for Post-Stabilization Care Services to an amount no greater than what the HMO would charge the Enrollee if he or she had obtained the services through HMO. HMO financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when: a Participating Provider with privileges at the treating Hospital assumes responsibility for the Enrollee's care; a Participating Provider assumes responsibility for the Enrollee's care through transfer; HMO representative and the treating Physician reach an agreement concerning the Enrollee's care; or; the Enrollee is discharged.

17.2.7 HMO shall reimburse those Physicians providing Emergency Services and Urgent Care services with whom HMO has a contract according to the terms of that contract.

17.2.8 HMO must reimburse a Non-Participating Provider for Emergency Services or Urgent Care services at the prevailing Medicare fee-for-service ("**FFS**") rate as applicable for that service. Where the Covered Service would traditionally be covered under Medicare FFS, the Medicare FFS rate applies. HMO shall ensure that Enrollees maintain balance billing protections as provided in Section 6.4 of this Contract.

3.2.9 In accordance with CalOptima Policies, HMO shall implement the CMS Quality Payment Program known as the Merit-based Incentive Payment System ("**MIPS**"). MIPS adjustments for Part B covered professional services furnished by MIPS-eligible Providers that are not contracted with HMO shall be administered in the same manner as any other changes in the applicable Medicare payment schedules. HMO shall make positive and negative payment adjustments as identified by CMS based on the CMS MIPS adjustment data files.

3.2.9.1 CalOptima or HMO may apply MIPS payment adjustments either at the time the payment is made during the applicable MIPS payment year or as a retrospective adjustment to paid claims.

3.2.9.2 CalOptima or HMO are required to demonstrate payment through reporting or attestation by the end of March on an annual basis.

17.3 **HMO Financial Responsibility**. If CalOptima receives a claim for Covered Services that are the financial responsibility of HMO, CalOptima shall forward such claim to HMO for payment, in accordance with the procedures set forth in Title 28 CCR Section 1300.71, "Claims Settlement Practices." CalOptima shall not pay for services that are HMO's financial responsibility unless HMO fails to make payment within the time allowed by State and federal laws and regulations, and CalOptima is required by law to make such payment. In such cases, CalOptima, after written notice to HMO and reasonable opportunity to cure, will make payment, and HMO shall reimburse CalOptima for such payments. If HMO fails to reimburse CalOptima, CalOptima may offset an

uncontested payment(s) against Capitation Payments or other amounts due from CalOptima to HMO, if any.

17.4 **Collection of Share of Cost**. HMO shall collect Medicare share of cost unless prohibited under this Contract.

17.5 **Capitation Payments**. HMO and/or Downstream Entities shall distribute monthly Capitation Payments to capitated Participating Providers within fifteen (15) calendar days following the date on which Physician receives payment from CalOptima.

17.6 **Claims Adjudication**. Except as provided in Section 3.1.1, HMO shall accept and adjudicate claims for Covered Services provided to Enrollees in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the CCR and CalOptima Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to claims processing and payment shall be prohibited.

17.7 **Dispute Resolution.** HMO shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the CCR and CalOptima Policies.

17.8 **Right of Appeal**. HMO shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to HMO's dispute resolution mechanism involving an issue of Medical Necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from Physician's Date of Determination.

17.9 **CalOptima Payment On Behalf Of Physician**. If CalOptima receives a copy of an unpaid Clean Claim as part of a Provider grievance that is thirty (30) working days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies. If HMO 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) working day period, CalOptima shall pay the Claim on behalf of Physician, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation Payment, in accordance with CalOptima Policies.

17.10 **Quarterly Claims Payment Performance Report.**

17.10.1 HMO shall submit, in a format specified by CalOptima Policies, a quarterly claims payment performance report ("**Quarterly Claims Report**") to CalOptima within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose HMO's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the CCR.

17.10.2 HMO shall ensure that each Quarterly Claims Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the CCR,

of HMO, stating that the report is true and correct to the best knowledge and belief of the principal officer.

17.10.3 HMO's Quarterly Claims Report shall include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to CalOptima.

17.11 **Forwarding of Misdirected Claims.**

17.11.1 HMO shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are the financial responsibility of the HMO. HMO will receive and forward misdirected claims per CalOptima Policy.

17.11.2 HMO shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that are the financial responsibility of CalOptima within ten (10) working days of receipt of the claim. CalOptima shall receive these files per CalOptima policy and load them into its system to ensure timely claims processing. HMO shall forward any claims that are not its payment responsibility to CalOptima within eight (8) calendar days of receipt, so that a total of only ten (10) working days will elapse prior to the claims being in the proper hands.

17.12 **Assumption of Delegated Functions**. In the event that HMO fails to timely and accurately reimburse its claims (including the payment of interest and penalties), CalOptima may, at its sole discretion, revoke the delegation and assume responsibility from HMO for claims payment, or terminate this Contract as provided for in Article XI. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that HMO has established an approved CAP consistent with Section 1375.4 (b)(4) of the Health and Safety Code and Section 11.3 of the Contract.

17.13 **Recoupment for Assumption of Claims Processing Obligations**. CalOptima, in its sole and absolute discretion, may reduce HMO's Capitation Payments to recoup additional administrative costs for the assumption of the claims processing obligations of HMO, as described in this Article III of Attachment D, as well as any amounts, including interest due, on claims unpaid at the assumption of such obligations by CalOptima.

XVIII. CLAIMS COMPLIANCE

18.1 **Claims Compliance Monitoring**. HMO understands that claims compliance programs are required by CalOptima's Regulators and agrees that delegation is contingent upon HMO's compliance with required monitoring and oversight activities, as outlined in CalOptima Policies. HMO agrees that CalOptima reserves the right to monitor HMO's claims compliance activities, notwithstanding any other audit, compliance, or contractual issue between HMO and CalOptima. In the event HMO demonstrates an inability to meet CalOptima's claims payment standards, CalOptima reserves the right to revoke and assume the delegated responsibilities described above.

18.2 **Claims Non-Compliance**. In the event that CalOptima determines that HMO is not in ninety-five percent (95%) compliance with any of the requirements of Attachment D the following actions will be applied:

18.2.1 Within thirty (30) days of an audit that documents non-compliance, CalOptima will issue a written warning to HMO that describes the non-compliance. HMO will respond within fifteen (15) working days of receiving the non-compliance notification with a written CAP to comply. Such CAP will describe the actions to be taken and the schedule by which those actions will be completed. CalOptima will review the CAP and advise HMO whether or not actions or time schedules are acceptable within fifteen (15) days of receiving it. CalOptima will conduct a follow-up audit of HMO's claims operation within ninety (90) days from the date of serving the non-compliance notification to verify compliance with Attachment D. If CalOptima does not receive a CAP within fifteen (15) calendar days, the consequences outlined in Subsection 4.2.2 of this attachment for continued non-compliance will apply.

18.2.2 If, as a result of CalOptima's follow-up audit, HMO is found to still be non-compliant with Attachment D within fifteen (15) calendar days of making that determination, CalOptima will notify HMO in writing of the continued non-compliance and may elect to provide consultative or other assistance to help establish, maintain and monitor continued administrative compliance or assume "joint administration" of HMO's claims operations, involving itself only with Enrollees' claims and allowing the operation to remain on HMO's premises. The Parties agree to meet and develop a mutually agreeable work plan for added staffing and work stations, the cost of which will be HMO's sole responsibility. CalOptima will develop a CAP with HMO's participation to assure maximum compatibility with HMO's ongoing operations. CalOptima will cooperate with HMO in implementing changes across all risk claims processed at that site, should HMO so request. Within fifteen (15) calendar days of receiving the second notice of non-compliance, HMO will provide a written response stating the specific action to be taken to establish compliance with the help of CalOptima. If CalOptima does not receive a CAP within fifteen (15) calendar days, the consequences outlined in Subsection 4.2.3 for continued non-compliance will apply. Within ninety (90) days from the date of serving the second notice of non-compliance, CalOptima will re-audit HMO's claims process and documents to determine final compliance or non-compliance.

18.2.3 If, as a result of its second follow-up audit, CalOptima reasonably determines that HMO is still non-compliant, CalOptima reserves the right to terminate this Contract for material breach upon ten (10) days' prior written notice and opportunity to cure.

18.2.4 HMO may resume sole administrative responsibility for claims processing if CalOptima determines that HMO has corrected the deficiencies that caused the non-compliance, and, as a result of resuming responsibility for claims processing, demonstrates compliance with the timely provider payments requirements set forth in Section 3.1 of this Attachment D.

18.2.5 With respect to the requirements of Attachment D, HMO will be subject to regular site-audits conducted by CalOptima to monitor all claims requirements.

V. CLAIMS FORWARDING

HMO shall forward any claims that are not its payment responsibility to CalOptima within ten (10) calendar days of receipt.

VI. SELF-MONITORING & REPORTING

HMO shall develop, implement and demonstrate upon request, a claims quality assurance process, including regular, scheduled, automated, or manual reports, self-testing procedures, and internal reporting to HMO's executive management of timeliness, payment accuracy, and denial accuracy (as required herein). Such self-monitoring and internal reporting shall involve use of industry standard tools and shall measure actual performance against the standards for DMHC and CMS compliance. CalOptima strongly recommends check issuance and mailing occur not less frequently than weekly and that HMO's internal reporting intervals match the intervals at which checks are issued, except that weekly reporting would be sufficient if checks are issued more often than weekly. At a point early in the beginning of operations under the Contract and in accordance with industry-wide CMS requirements, CalOptima will require that HMO submit monthly reports to CalOptima using the industry-standard Monthly Report of Claims Processing Timeliness and Overall Percent of Denial Accuracy format. Those reports must be received by CalOptima not later than the fifteenth (15th) calendar day of each month.

VII. AUDITS & AUDIT PREPARATION

Article IV, above, provides detailed, specific processes involving claims non-compliance. Even when HMO does meet compliance standards and successfully concludes any time periods where denials must be submitted to CalOptima for review, CalOptima will continue to schedule (1) periodic audits, (2) random, focused audits, and (3) focused reviews based on appeals and grievance results to monitor HMO's compliance with CMS regulations. Prior to the scheduled arrival of CalOptima's auditor, HMO shall retrieve claims and related documents in accordance with instructions provided to HMO by CalOptima in its letter confirming the appointment.

VIII. SPECIAL STUDIES

8.1 In the event DMHC and/or CMS requires that CalOptima conduct any special compliance study or effort, HMO shall support the study and will be subject to any DMHC and/or CMS specified time schedules or deadlines for corrective actions.

IX. FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

9.1 HMO shall meet federal requirements for access to FQHC services, including those in 42 U.S.C. § 1396 b(m). HMO shall reimburse FQHCs and RHCs in accordance with current Laws. If FQHC and RHCs services are not available in the Provider network, HMO shall authorize out-of-network services subject to the prevailing MA payment requirements for out-of-network services.

9.2 HMO shall ensure that its payments to FQHCs and RHCs for services to Enrollees are no less than the sum of the level and amount of payment that the Health Network or CalOptima would make for such services if the services had been furnished by an entity providing similar services that was not an FQHC and RHC. The intent of these provisions is to ensure that HMO pays FQHCs and RHCs amounts consistent with Medicare managed care policies while preserving the opportunity for FQHCs to separately claim supplemental payments under such policies.

X. INDIAN HEALTH CARE PROVIDERS

10.1 HMO shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that HMO would pay to a network FQHC that is not an Indian Health Care Provider, including any supplemental payment from the State to make up the difference between the contract amount and what the Indian Health Care Provider would have received FFS.

10.2 When the amount the Participating Provider Indian Health Care Provider receives from the HMO is less than the amount the Indian Health Care Providers would receive FFS, the State must make a supplemental payment to the Indian Health Care Provider that the Indian Health Care Provider would receive FFS or the applicable encounter rate.

10.3 HMO shall not impose enrollment fees, premiums, or similar charges on Indians served by an Indian Health Care Provider or through referral under contract health services. HMO must exempt from all cost-sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian Health Care Provider or through referral under contract health services.

10.4 HMO shall reimburse Indian Health Care Providers promptly who provide Covered Services to Indian Enrollees, who are eligible to receive Covered Services, at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service, and HMO shall ensure any retroactive outpatient per visit rates are appropriately reimbursed to the Indian Health Care Provider.

ATTACHMENT E
STATUTORY AND REGULATORY COMPLIANCE TERMS

1. **Compliance with State and Federal Laws**. HMO acknowledges that CalOptima is subject to certain State and federal laws, regulations, and instructions governing its MA Program. HMO shall comply with all Laws and DMHC and CMS administrative bulletins, plan letters and instructions. HMO understands that payments made by CalOptima are, in whole or in part, derived from federal funds, and therefore HMO and any Downstream Entities are subject to certain laws that are applicable to individuals and entities receiving federal funds, including the following: (i) Title VI of the Civil Rights Act of 1964; (ii) Sections 503 and 504 of the Rehabilitation Act of 1973; (iii) the Age Discrimination Act of 1975; (iv) the Americans with Disabilities Act of 1990; (v) the Vietnam Era Veteran's Readjustment Assistance Act; and (vi) Title IX of the Education Amendments of 1972. Any provision required to be in this Contract by the CMS Contract, the Knox-Keene Act, Title 28 of the California Code of Regulations, Medicare laws and regulations, DMHC or CMS instructions and reporting requirements and other applicable laws, shall bind CalOptima, HMO, and Downstream Entities, whether or not specifically set forth in this Contract.

2. **Compliance with CalOptima's Contractual Obligations**. All services and other activities furnished by HMO and Downstream Entities must be performed in accordance with CalOptima's contractual obligations to CMS.

3. **Compliance with FWA Requirements**. HMO, and its employees, agents and Downstream Entities performing services under this Contract, shall comply with CalOptima's Compliance Program including, its FWA plan. Prior to performing services under this Contract, HMO shall complete and submit to CalOptima, any CMS-required training and/or CalOptima-required attestations related to such training and other compliance obligations. HMO agrees to comply and will have any Downstream Entity agree to comply with CalOptima standards and policies.

4. **Fraud and Abuse Reporting**. HMO shall, in accordance with all Laws, report to CalOptima all cases of suspected fraud and/or abuse relating to the rendering of Covered Services within five (5) days of the date when HMO first becomes aware of or is on notice of such activity.

5. **CMS Participation Requirements**. HMO represents and warrants that: (i) neither HMO nor any of its HMO Physician, employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("**Federal Health Care Program(s)**"); (ii) HMO has not arranged or contracted (by employment or otherwise) with any employee, contractor or agent that HMO knows or should know are excluded or precluded from participation in Federal Health Care Programs; (iii) no action is pending against HMO or any of its HMO Physicians, employees, or agents performing services under this Contract to suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) HMO will immediately notify CalOptima if it learns that it is or has employed or contracted with a person or entity that is excluded from participation in any Federal Health Care Program. If HMO fails to comply with this Section 5 of this attachment, CalOptima reserves the right to require HMO to pay immediately to CalOptima the amount of any sanctions or other penalties that may be imposed on CalOptima by CMS for violation of this prohibition, and HMO shall be responsible for any resulting overpayments. HMO shall not make payment for a healthcare item or service furnished by an individual or entity that is excluded by the Office of the Inspector General or is included on the Preclusion List. HMO shall provide written notice to the Enrollee 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. HMO shall ensure that

all Participating Providers that provide Covered Services do not appear on the CMS Preclusion List in order to receive reimbursement for claims or otherwise participate in the Medicare program.

6. **Confidentiality of Enrollee Information**. HMO, its Downstream Entities, and their employees and agents shall comply with the specific confidentiality obligations set forth below.

6.1 HMO, Downstream Entities, and their employees and agents 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 them as a result of services performed under this Contract, except for statistical information not identifying any such person. HMO, Downstream Entities, and their employees and agents shall not use such identifying information for any purpose other than carrying out HMO's obligations under this Contract.

6.2 HMO, Downstream Entities, and their employees and agents shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Enrollee. HMO shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Enrollee, any such identifying information to anyone other than CMS, DMHC, or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

6.3 Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with 42 CFR Section 431.300 *et seq*., Welfare and Institutions Code Section 14100.2, 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 Enrollees shall be protected by HMO from unauthorized disclosure. HMO may release Medical Records in accordance with Laws pertaining to the release of this type of information. HMO is not required to report requests for Medical Records made in accordance with Laws.

6.4 With respect to any identifiable information concerning an Enrollee under this Contract that is obtained by HMO or its Downstream Entities from CalOptima's Regulators, HMO will, at the termination of this Contract, return all such information to CalOptima's Regulators if required by them, or maintain such information according to written procedures provided to HMO by CalOptima and/or CalOptima's Regulators for this purpose.

7. **Offshore Subcontracts**. HMO shall provide, and ensure that Downstream Entities provide, to CalOptima information and attestations related to the provision of any services under this Contract in a country other than the United States ("**Offshore Subcontractor**") to enable CalOptima to comply with CMS reporting obligations. Such information shall be submitted to CalOptima prior to engaging any Offshore Subcontractor for purposes of this Contract, and such Offshore Subcontractors are subject to approval by CalOptima.

8. **Required Disclosures**. In accordance with 42 CFR Section 1002.3, HMO shall immediately notify CalOptima in the event any sanctioned person (as defined in 42 CFR Section 1001.1001(a)(1)) owns or controls HMO.

9. **Equal Opportunity**. HMO and Downstream Entities shall comply with the following Equal Opportunity requirements set forth below.

9.1 HMO and its Downstream Entities 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. HMO and its Downstream Entities 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. Physician and its Downstream Entities agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the federal government, 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 HMO and its Downstream Entities' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

9.2 HMO and its Downstream Entities will, in all solicitations or advancements for employees placed by or on behalf of HMO and its Downstream Entities, 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.

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

9.4 HMO and its Downstream Entities will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR Part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

9.5 HMO and its Downstream Entities will furnish all information and reports required by Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation

Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and HMO 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.

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

9.7 HMO and its Downstream Entities will include the provisions of Sections 10.1 through 10.7 of this attachment in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR Part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. Section 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Downstream Entity. Physician and its Downstream Entities will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or CMS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that in the event HMO and/or its Downstream Entities become involved in, or are threatened with litigation by a other Downstream Entity or vendor as a result of such direction by CMS, HMO and its Downstream Entities may request in writing to CMS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

10. **Non-Discrimination**. HMO and Downstream Entities shall comply with the non-discrimination requirements set forth below.

10.1 During the performance of this Contract, neither HMO nor any Downstream Entities shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC)), medical condition (including cancer), mental disability, marital status, age (over 40), or the use of family and medical care leave and pregnancy disability leave. HMO and Downstream Entities shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. HMO and Downstream Entities 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, 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. HMO and Downstream Entities shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. HMO shall include the non-discrimination and compliance provisions of this Section 10.1 in all Downstream Entity subcontracts to perform work under this Contract.

10.2 HMO and all Downstream Entities shall abide by Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1972 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the Physician nor Downstream Entities shall discriminate against Enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C., Section 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); rules and regulations promulgated pursuant thereto, or as otherwise provided by Laws.

10.3 For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Enrollee any Covered Services or availability of a facility; (ii) providing to an Enrollee 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 Enrollees under this Contract, except where medically indicated; (iii) subjecting an Enrollee to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting an Enrollee in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating an Enrollee differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

10.4 HMO shall take affirmative action to ensure that all Enrollees are provided Covered Services without unlawful discrimination, except where medically indicated. For the purposes of this Section 10.4, physical handicap includes the carrying of a gene that may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

10.5 Physician shall act upon all complaints alleging discrimination against Enrollees in accordance with CalOptima's Policies and shall forward copies of all such grievances to CalOptima within five (5) days of receipt of same.

11. **Smoke Free Workplace**. Public Law 103-227, also known as the Pro Children Act of 1994 ("**Pro Children Act**"), requires that smoking not be permitted in any portion of any indoor facility owned

or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education, or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, HMO certifies that it will comply with the requirements of the Pro Children Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Pro Children Act. Physician further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Pro Children Act.

12. **Air or Water Pollution Requirements**. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. HMO 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.

13. **Lobbying Restrictions and Disclosure Certification**. Any federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C. must comply with the following lobby restrictions and disclosures.

13.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or sub-grant, which is subject to 31 U.S.C. Section 1352 and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in **Attachment E-1**, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Subsection 13.6 of this attachment.

13.2 Each recipient shall file a disclosure (in the form set forth in **Attachment E-2**, entitled "Standard Form-LLL 'Disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Section 13.6 of this attachment if paid for with appropriated funds.

13.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Section 13.2 of this attachment. An event that materially affects the accuracy of the information reported includes: (i) 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; (ii) a change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or (iii) 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.

13.4 Each person (or recipient) who requests or receives, from a person referred to in Section 13.1 of this attachment, a contract, subcontract, grant or sub-grant exceeding $100,000 at

any tier under a contract or grant shall file a certification and a disclosure form, if required, to the next tier above.

13.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Section 13.1 of this attachment.

13.6 31 U.S.C. Section 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.

14. **Debarment Certification**. HMO agrees to comply with applicable Federal suspension and debarment regulations including 7 CFR § 3017, 45 CFR §76, 40 CFR § 32, or 34 CFR § 85.

14.1 HMO certifies to the best of its knowledge and belief, that it and its principals:

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

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

(iii) 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 sub-provision (ii) herein;

(iv) Have not within a three (3)-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

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

(vi) Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

14.2 If HMO is unable to certify to any of the statements in this certification, the Physician shall submit an explanation to CalOptima.

14.3 The terms and definitions in this Section 14 have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

14.4 If HMO knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause or default.

15. **Downstream Entity Contracts**. If any services under this Contract are to be provided by a Downstream Entity subcontracted by HMO, HMO shall ensure that such subcontracts comply with 42 CFR Sections 422.504, 423.505 and 438.6(l). Such subcontracts shall include all language required by CMS as provided in Attachment F**.**

16. **Other Statutory and Compliance Terms**. HMO shall not contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a Hospital):

16.1 Furnished by HMO by any individual or entity during any period when the individual or entity is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156 or 1842(j)(2);

16.2 Furnished at the medical direction or the prescription of a physician, during the period when such physician is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had some reason to know, of the exclusion (after a reasonable time period and after reasonable notice has been furnished to the person);

16.3 Furnished by an individual or entity to whom the State has suspended payments to during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments;

16.4 HMO may not pay for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997

ATTACHMENT E-1
CERTIFICATION REGARDING LOBBYING

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATIN REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities'' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of HMO	Printed Name of Person Signing for HMO
Contract / Grant Number	Signature of Person Signing for HMO
Date	Title

After execution by or on behalf of HMO, please return to:

CalOptima
Attn: Regulatory Affairs
505 City Parkway West
Orange, California 92868

ATTACHMENT E-2

CERTIFICATION REGARDING LOBBYING

Approved by OMB

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
0348-0046 (See reverse for public burden disclosure)

<table>
<tr><td>1. Type of Federal Action:
contract
grant
cooperative agreement loan
loan guarantee
loan insurance</td><td colspan="2">2. Status of Federal Action:
bid/offer/application initial
award post-award</td><td>3. Report Type:
initial filing
material change

For Material Change Only:
Year _____ quarter_____
date of last report</td></tr>
<tr><td colspan="2">4. Name and Address of Reporting Entity:
Prime Subawardee Tier, if known:</td><td colspan="2" rowspan="2">5. If Reporting Entity in No. 4 is Subawardee,
Enter Name and Address of Prime:

Congressional District, If known:</td></tr>
<tr><td colspan="2">Congressional District, If known:</td></tr>
<tr><td colspan="2">6. Federal Department/Agency:</td><td colspan="2">Federal Program Name/Description:
CDFA Number, if applicable:</td></tr>
<tr><td colspan="2">8. Federal Action Number, if known:</td><td colspan="2">9. Award Amount, if known:</td></tr>
<tr><td colspan="2">10. a. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):
(attach Continuation Sheets(s)</td><td colspan="2">b. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):
SF-LLL-A, If necessary)</td></tr>
<tr><td colspan="2">Amount of Payment (check all that apply):
$ actual planned</td><td colspan="2" rowspan="3">13. Type of Payment (check all that apply):
a. retainer
b. one-time fee
c. commission
d. contingent fee
e. deferred
f. other, specify:</td></tr>
<tr><td colspan="2">Form of Payment (check all that apply):
a. cash
b. in-kind, specify: Nature</td></tr>
<tr><td colspan="2">Value</td></tr>
</table>

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	

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
SUBCONTRACT REGULATORY TERMS

A. **General Terms**: Language addressing the following matters shall be included in Downstream subcontracts:

1. The right of CalOptima's Regulators to monitor, audit, evaluate, inspect and have access to books, records and other information as provided in this Contract.
2. CalOptima's Regulators' right to inspect, evaluate, and audit any pertinent information related to the Contract for a period of ten (10) years from the final date of the contract period or from the date of completion of any audit as provided in this Contract.
3. Prohibitions against holding Enrollees liable for payment of any fees that are the obligation of CalOptima or the HMO, as applicable.
4. The services are in accordance with CalOptima's obligations to CMS and applicable CalOptima Policies.
5. The obligations of Downstream Entities to protect Enrollee privacy and confidentiality including health records, as provided in this Contract.
6. The obligation to comply with all federal and state laws, regulations and CMS instructions, including those laws that must be incorporated into such Downstream subcontracts as indicated in this Contract.
7. Language related to the obligations to submit timely and accurate Encounter Data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.
8. All requirements included in Attachment E not expressly addressed herein.

B. **Delegation Terms**. If, and to the extent that sub-delegation is permitted by CalOptima and HMO obtains CalOptima's approval as provided in this Contract, Downstream Entity subcontracts must include:

1. Language that specifies (i) the delegated activities and reporting requirements; (ii) that provides for revocation of the delegated activities and other remedies in the event CalOptima or CalOptima's Regulators find that the delegated party as not performed satisfactorily; (iii) that the performance of the parties is monitored by CalOptima on an ongoing basis; and (iv) that CalOptima may impose corrective action as necessary.
2. If the subcontract relates to credentialing of medical providers, language that the credentials of medical professionals affiliated with the party or parties will either be reviewed by CalOptima or the credential process will be reviewed and approved by CalOptima and that CalOptima must audit the process on an ongoing basis.
3. If the subcontract delegates selection of providers it must include language that CalOptima retains the right to approve, suspend or terminate any such arrangement and that CalOptima shall provide a written statement to a provider of the reason or reasons for the termination with cause.

C. **Medical Provider Downstream Subcontract Terms**.

All subcontracts or arrangements with medical providers shall include provisions addressing:

1. The term of the contract, including the beginning and ending dates as well as methods of extension, renegotiation and termination and full disclosure of the method and amount of compensation or other consideration.

2. The obligation to pay contracted medical providers under the terms of the contract and prompt payment provision, the terms of which are developed and agreed to by the parties.

3. The obligations to provide services in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic background and provide interpreter services for Enrollees at all provider sites.

4. The obligation to (i) abide by all federal and state laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information; (ii) to ensure that medical information is released in accordance with applicable federal or state law, or pursuant to court orders or subpoenas; (iii) to maintain Enrollee records and information in an accurate and timely manner; and (iv) to ensure timely access by Enrollees to the records and information that pertain to them.

5. The obligation to hold CalOptima, CalOptima's Regulators and Enrollees harmless in the event that HMO cannot or will not pay for services performed by the Downstream Entity and for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees.

6. Medical providers' EMTALA obligations and that they must not create any conflicts with hospital actions required to comply with EMTALA.

7. Language prohibiting providers, including PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees.

8. Language that prohibits the Downstream Entity from refusing to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has in good faith: (a) Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the 'Downstream Entity's health benefit plans as they relate to the needs of such Provider's patients; or (b) communicated with one or more of his or her prospective, current or former patients with respect to the method by which such Provider is compensated by the Downstream Entity for services provided to the patient.

9. Language that states the Provider is not required to indemnify the HMO for any expenses and liabilities, including judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the HMO based on its management decisions, utilization review provisions or other policies, guidelines or actions.

10. The obligation of the medical provider to assist CalOptima in the transfer of care, including in the transfer of care in the event of sub-subcontract termination for any reason.

11. Acknowledgement that assignment or delegation of the subcontract will be void unless prior written approval is obtained from CMS and CalOptima.

12. 'The Provider's right to submit a grievance and a description of the formal process to resolve the Provider's grievances.

13. The obligation to participate and cooperate in HMO's Quality Improvement System.

14. Language addressing requirements related to payment of Non-Participating Provider emergency and post-stabilization services.

ATTACHMENT G
CMS SPECIFIC PROGRAM PERFORMANCE REQUIREMENTS

1. HCC Coding Requirements and Performance Improvement Activities

1.1 CMS pays CalOptima health-based capitation to compensate CalOptima for services rendered to Enrollees. CMS utilizes encounter data to assign Hierarchical Condition Categories ("**HCC**") to Enrollees. The Enrollee's HCC determines the payment amount received by CalOptima accounting for the variation in expenditures for Medicare Enrollees based on an Enrollee's health status.

1.2 HMO shall submit Enrollee-specific accurate encounter and service data. Encounters are to be submitted no less than monthly using the ANSI 837P and/or 837I format version 5010 as appropriate, or current format as required by CalOptima.

1.3 HMO shall support and aid CalOptima's review of encounters, including to production and/or access of supporting medical records.

1.4 To enhance encounter submission accuracy and completeness, CalOptima has initiated performance improvement activities ("**PIAs**"). These PIAs include Enrollee medical and behavioral health assessments provided in the home or a residential facility.

1.5 HMO has the option to perform these PIAs provided HMO can demonstrate that HMO's PIAs meet all CalOptima standards and guidelines. Should HMO not perform the PIAs or HMO's PIAs not meet CalOptima standards and guidelines as determined by CalOptima, CalOptima shall perform these activities on behalf of HMO and the cost for these PIAs shall be charged to or shared with HMO. CalOptima will provide sixty (60) days' notification prior to taking any such action.

2. ESRD Waiver Responsibilities

2.1 HMO shall demonstrate to CalOptima that HMO administers a CalOptima-approved complex case management program for all End Stage Renal Disease (ESRD) Enrollees, which is in accordance with CMS requirements and CalOptima Policies and standards.

2.2 CalOptima shall advise HMO if its ESRD complex case management program does not meet CMS requirements and CalOptima Policies and clinical standards. If HMO cannot meet requirements as provided by CalOptima, CalOptima shall have the option to de-delegate the HMO for the management of ESRD Enrollees and retain a portion of the Capitation Payment for ESRD Enrollees commensurate with the costs for providing or outsourcing such services.

2.3 CalOptima shall provide notification to HMO of the intent to de-delegate. HMO shall have the opportunity to submit a corrective action plan to CalOptima in accordance with CalOptima policy.

3. Appeals Rights

HMO may appeal CalOptima's decision to take the actions outlined above, by filing a complaint pursuant to CalOptima Policies. If HMO is dissatisfied with the result of any appeal; it shall proceed in accordance with CalOptima's legal claims and judicial review policy.