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

FEBRUARY 1, 2024
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

Clayton Corwin, Chair	Isabel Becerra, Vice Chair
Debra Baetz	Maura Byron
Supervisor Doug Chaffee	Blair Contratto
Norma García Guillén	José Mayorga, M.D.
Supervisor Vicente Sarmiento	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_lKqR-pmTSTKz9Ul4Ipf9IA** and Join the Meeting.

Webinar ID: **897 9414 5557**

Passcode: **755906** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS
1. Ceremonial Oath of Office – Director Maura Byron

2. United Way Presentation

3. 29th Annual Report on the Conditions of Children in Orange County

MANAGEMENT REPORTS
4. Chief Executive Officer Report

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

CONSENT CALENDAR
5. Minutes
   a. Approve Minutes of the December 7, 2023 Regular Meeting of the CalOptima Health Board of Directors
   b. Receive and File Minutes of the October 17, 2023 Special Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

6. Approve New CalOptima Health Policy GG.1357 Population Health Management Transitional Care Services

7. Authorize Actions Related to Membership of the CalOptima Health Board of Directors' Finance and Audit Committee and Quality Assurance Committee

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

9. Approve Actions Related to Federal Advocacy Services

10. Approve Actions Related to State and Local Advocacy Services

11. Ratify and Authorize Actions Related to Contracts for Professional Services to Support Information Technology Services

12. Authorize Utilization of a Customized Contract to Execute an Amendment with Sitecore

13. Receive and File Closed and Open Board Ad Hoc Committees

14. Receive and File:
    a. November and December 2023 Financial Summaries
    b. Compliance Report
    c. Federal and State Legislative Advocates Reports
    d. CalOptima Health Community Outreach and Program Summary

REPORTS/DISCUSSION ITEMS

15. Authorize Actions Related to the Medi-Cal School Mental Health Provider Contracts

16. Approve the CalOptima Health Comprehensive Community Cancer Screening and Support Program Initiatives and Actions to Develop and Release a Notice of Funding Opportunity

17. Approve Actions Related to the Homelessness Prevention and Stabilization Pilot Program

18. Authorize Actions Related to Public Housing Authorities in Orange County

19. Select and Enter into Grant Agreements with Street Medicine Providers

20. Approve Actions Related to Expanding Intergovernmental Transfer Funding Partners

ADVISORY COMMITTEE UPDATES

21. Regular Joint Meeting of the Member Advisory Committee and the Provider Advisory Committee Update

CLOSED SESSION

CS-1. PUBLIC EMPLOYEE PERFORMANCE EVALUATION Pursuant to Government Code Section 54957(b)(1): CHIEF EXECUTIVE OFFICER MICHAEL HUNN

CS-2. CONFERENCE WITH LEGAL COUNSEL – STRATEGY ON EXISTING LITIGATION Pursuant to Government Code Section 54956.9(d)(1)

CS-3. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Pursuant to Government Code Section 54956.9(d)(2) or (3): 2 Cases

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 February 1, 2024 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_lKqR-pmTSTKz9Ul4Ipf9IA

To **Join** from a PC, Mac, iPad, iPhone or Android device:
https://us06web.zoom.us/s/89794145557?pwd=PdbOE6XGfB9axxLFBF2pPJsCxmgt34.1

Passcode: 755906

Or One tap mobile:
+16694449171,,89794145557#,,,,*755906# US
+17193594580,,89794145557#,,,,*755906# 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 +1 386 347 5053 or +1 507 473 4847 or +1 564 217 2000 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

Webinar ID: 897 9414 5557
Passcode: 755906
International numbers available: **https://us06web.zoom.us/u/kb9nj1b3oL**

PRESENTATIONS/INTRODUCTIONS

1. Ceremonial Oath of Office – Director Maura Byron

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Whatever it Takes℠

CalOptima Health Board

February 1, 2024

Presented by:

BECKS HEYHOE

Executive Director, United to End Homelessness
Orange County United Way

CalOptima Health

UNITED TO END HOMELESSNESS℠
Empowered by Orange County United Way

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WHAT IT IS

Whatever it Takes℠

- Serves CalOptima Health members who are experiencing homelessness or housing insecurity
- Developed to complement CalAIM's Housing Transition Navigation & Deposit services and enhance support to CalOptima Health provider agencies
- Program features:
  1. Whatever it Takes Fund
  2. Training & Technical Assistance
  3. Housing Location Services

WIT COMPLETES THE HOUSING PUZZLE

CalOptima Health

CalAIM HOUSING TRANSITION NAVIGATION SERVICES

CalOptima Health

CalAIM HOUSING DEPOSIT

Whatever it Takes℠

1. **WHATEVER IT TAKES FUND**
2. **TRAINING & TECHNICAL ASSISTANCE**
3. **HOUSING LOCATION SERVICES**

WHATEVER IT TAKES FUND

Whatever it Takes℠

35

CalAIM Housing Agencies Already Onboarded!

284

Requests for Assistance Already Made!

Top 3 Claim Types

1. Transportation
2. Furnishings
3. Landlord Incentives*

“The Whatever it Takes program is helping to remove barriers by providing flexible funding that isn’t available anywhere else.”

— **Jetti Outfleet**
Accounting and Compliance Assistant, Friendship Shelter

** Landlord Incentives: double security deposits, holding fees, bonuses*

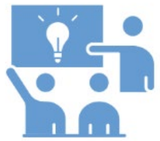
JOURNEY TO 100 · United Way Orange County United Way · CalOptima Health · UNITED TO END HOMELESSNESS℠ Empowered by Orange County United Way

WORKING TOGETHER

Whatever it Takes℠

Training and Technical Assistance:

Through Whatever it Takes, CalAIM Housing Providers have access to:



Comprehensive trainings led by local and national experts

Peer learning sessions aimed at increasing staff knowledge of homeless services and system processes

Housing Location Services:

WelcomeHomeOC staff source housing inventory and partner with CalAIM Housing Providers for successful lease-ups

Nationally recognized housing navigation program endorsed by local and state apartment associations

QUESTIONS?

BECKS HEYHOE

BecksH@UnitedWayOC.org
949.263.6112

THE 29TH ANNUAL REPORT ON THE

CONDITIONS OF CHILDREN IN ORANGE COUNTY

ocgov.com

FIRST 5 ORANGE COUNTY

first5oc.org

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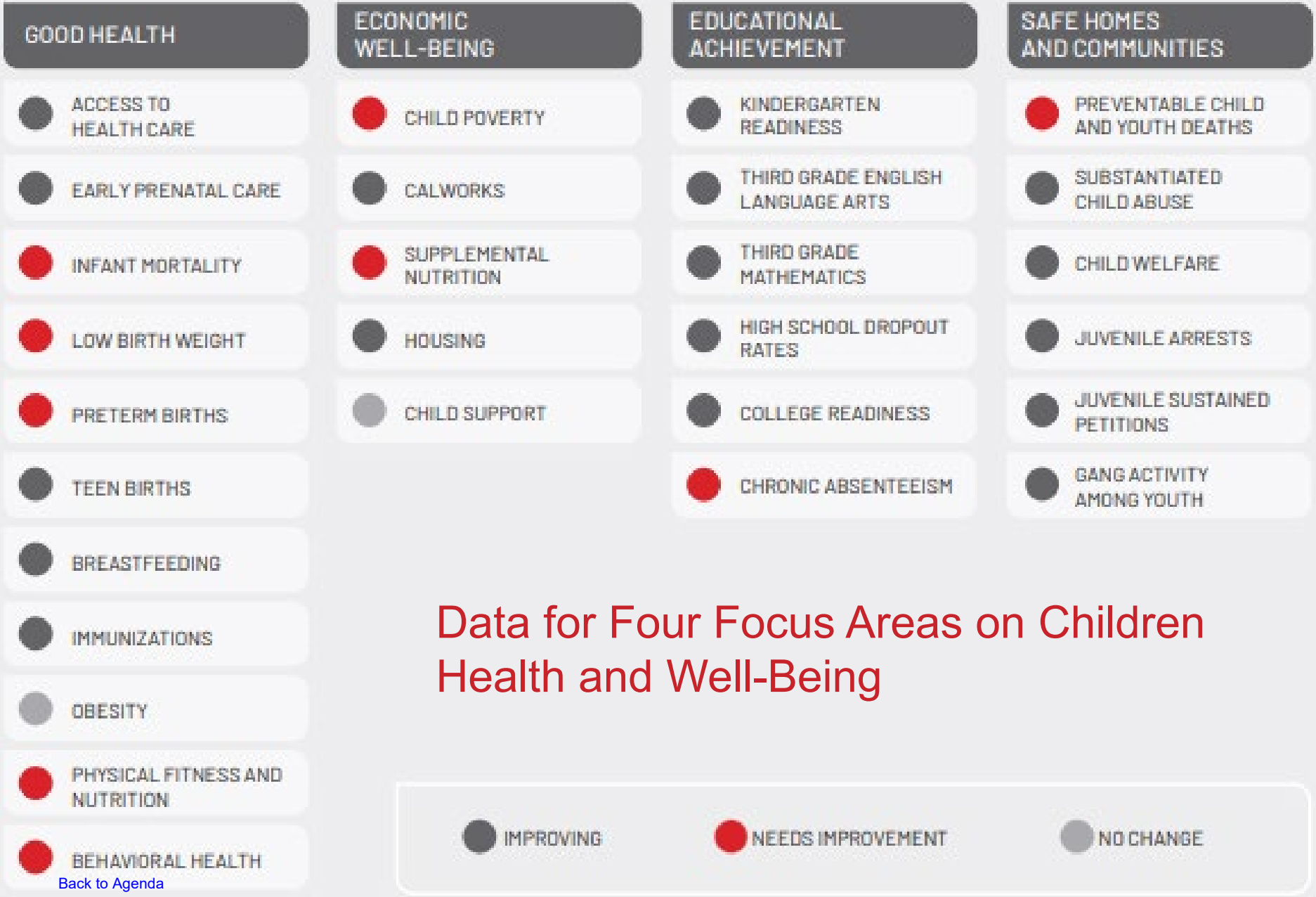

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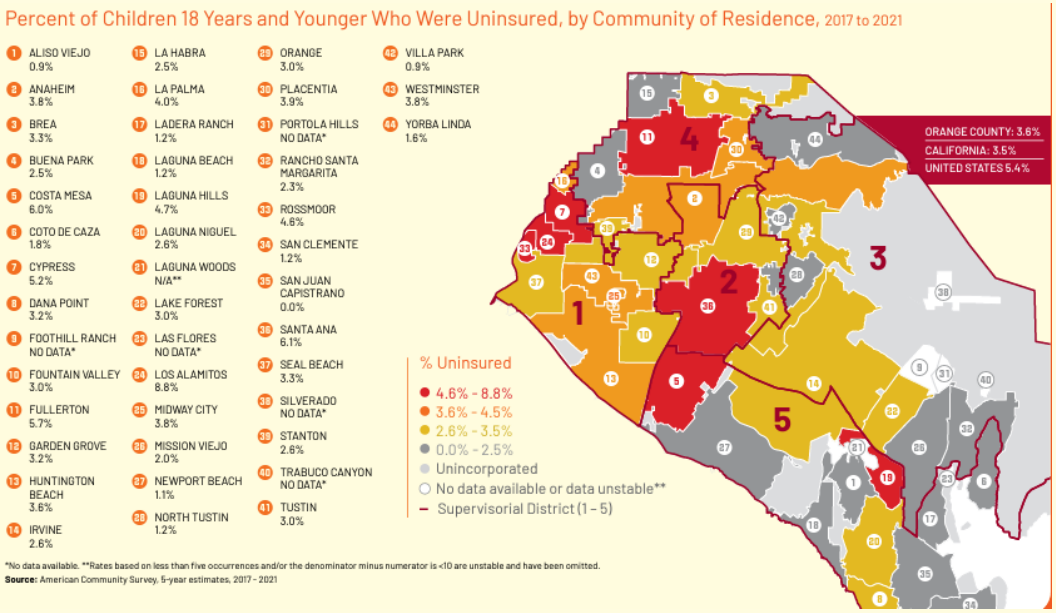
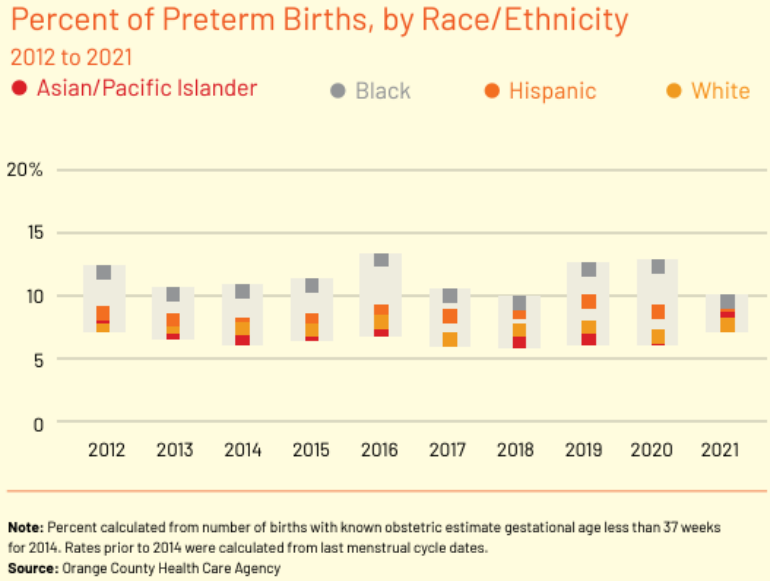
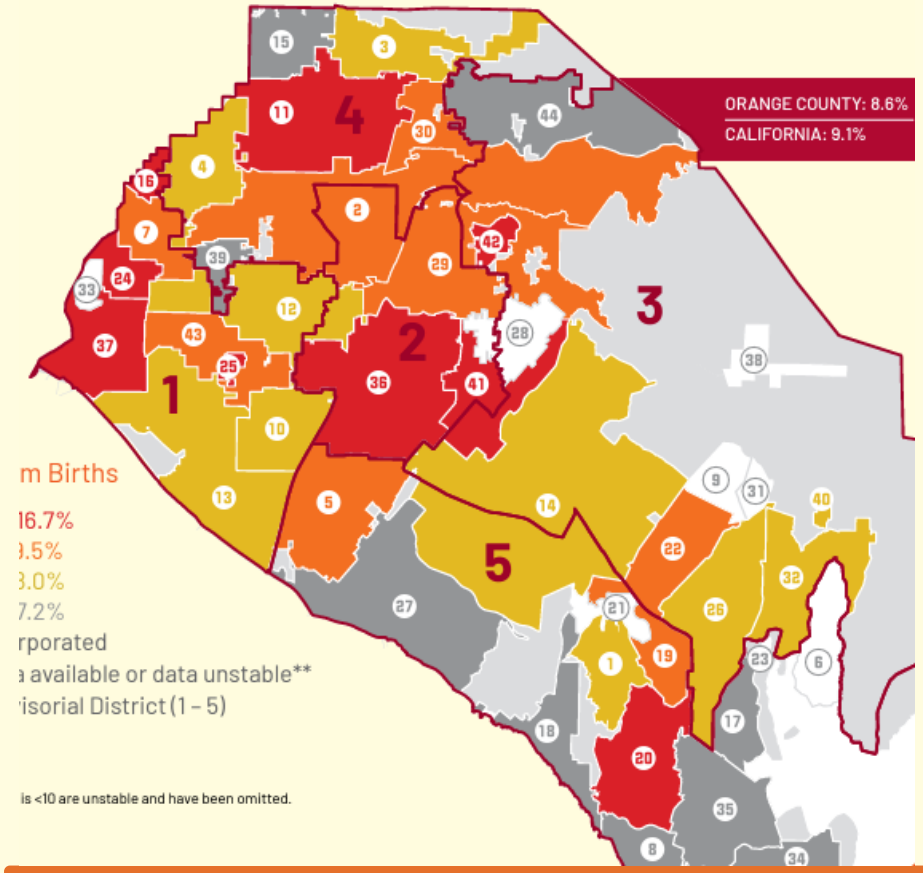
Data Visualizations



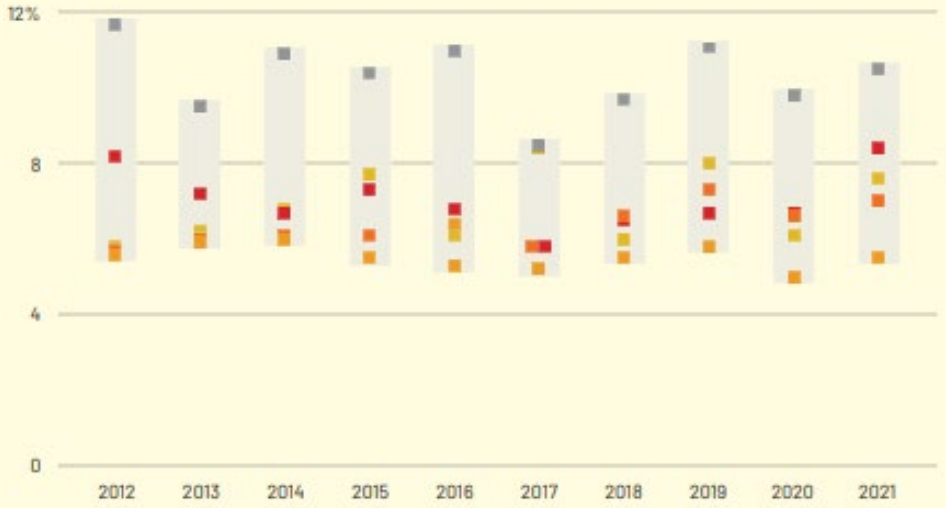


Prenatal Care and Birth Outcomes

Percent of Preterm Births by Community of Residence



Percent of Infants with Low Birth Weight, by Race/Ethnicity



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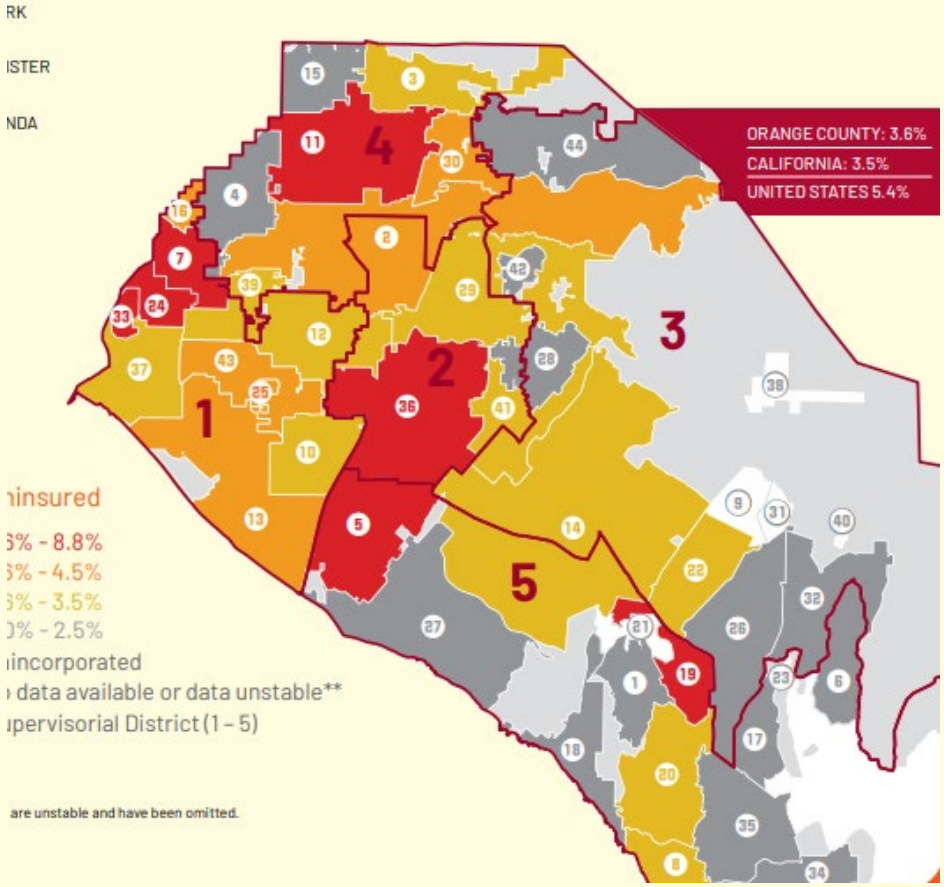
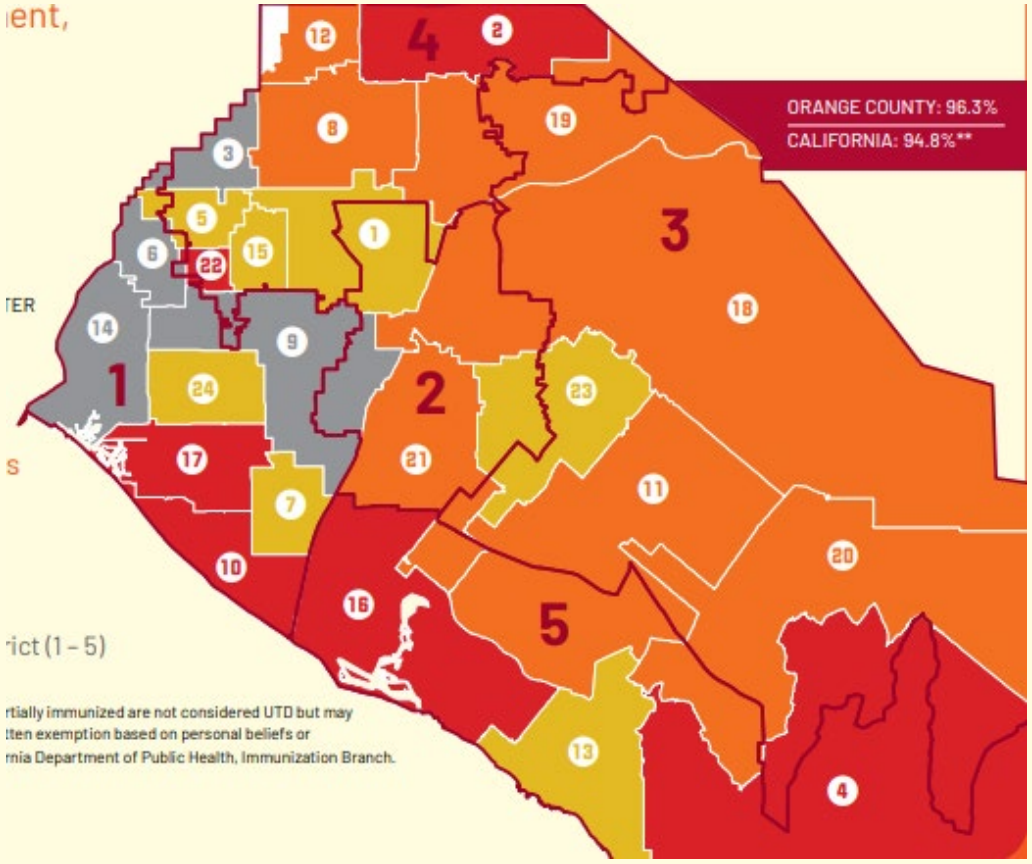
Preventative Care

Percent of Uninsured Children



Percent of Kindergartner's Up-To-Date on Vaccines



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Preventative Care Screening

Chlamydia Screening

Number of STD's Among Youth 10-17 Years of Age, by Gender and Type of Disease, 2013 to 2022

Type of STD*	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Chlamydia										
Male	129	136	123	155	159	134	140	108	93	102
Female	434	485	522	539	535	527	520	428	377	363
Unknown	0	0	3	2	3	8	7	8	11	15
Total	563	621	648	696	697	669	667	544	481	480

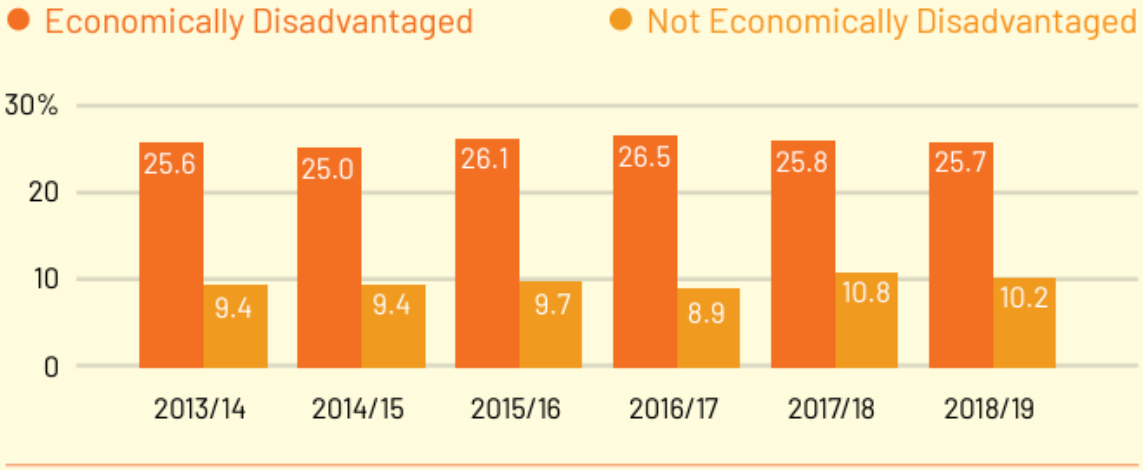
Blood Lead Screening

Number of Individual Children Ages 0-20 Years with Elevated Blood Lead Levels (EBLL), 2021*

	BLL <3.5µg/dL	BLL <3.5µg/dL % (row)	BLL ≥3.5 µg/dL	BLL ≥3.5 µg/dL % • (row)	Total number of children with a BLL
Age <6	24,912	98.54%	368	1.46%	25,280
Ages 6 to 20	2,018	98.54%	30	1.46%	2,048
Total Ages 0-20	26,930	98.54%	398	1.46%	27,328

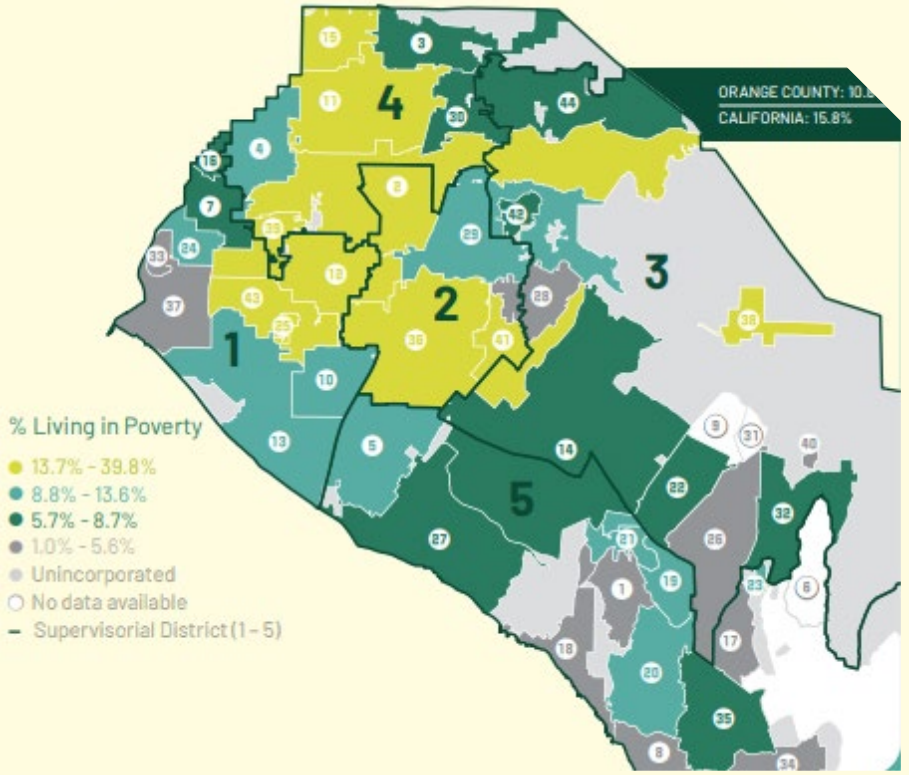
Obesity and Socioeconomic Status

Percent of 5th Grade Students who were Obese by Socioeconomic Status



Source: California Department of Education, DataQuest, 2018/19

Percent of children under 19 years living in poverty



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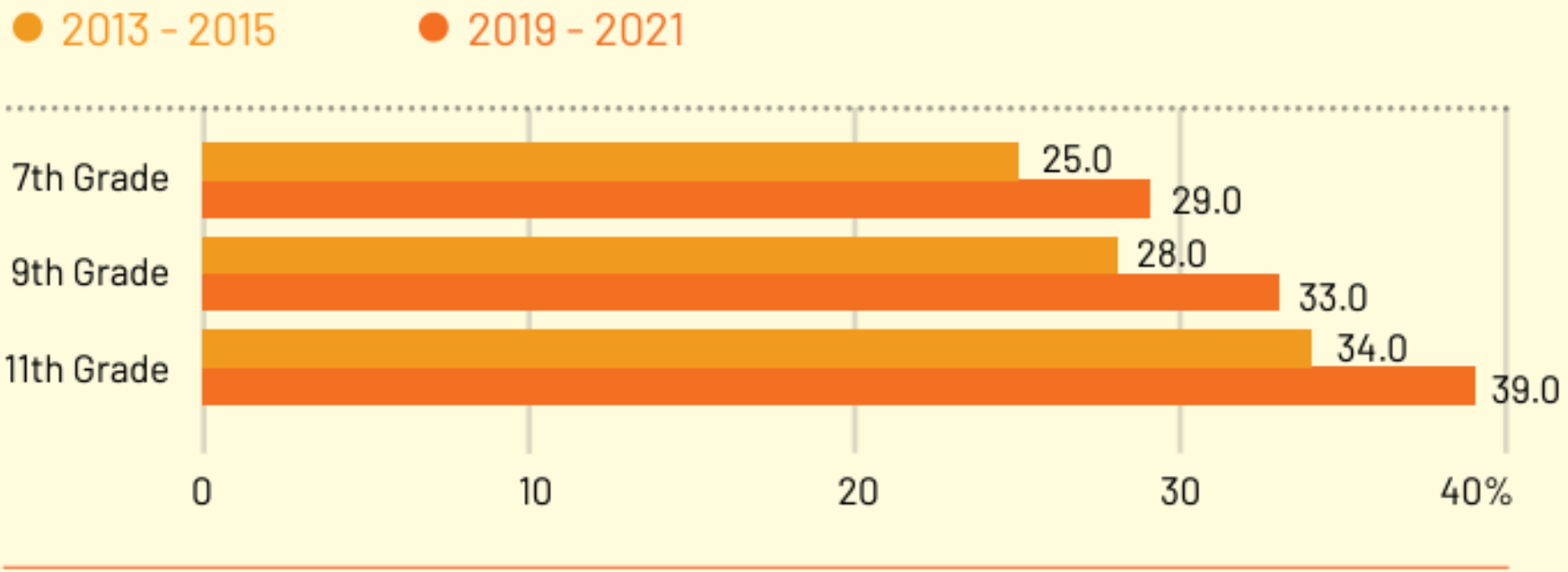
Behavioral Health

Students who Reported Experiencing Depression-Related Feelings, by Grade Level, Orange County, 2013 - 2015 and 2019 - 2021



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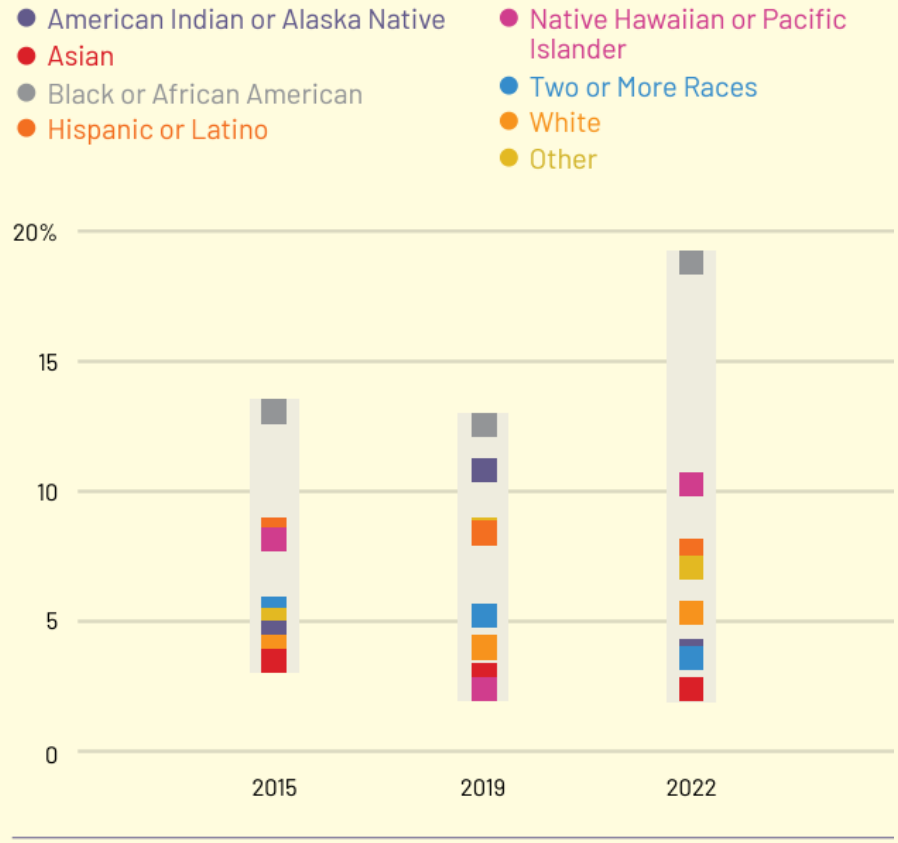
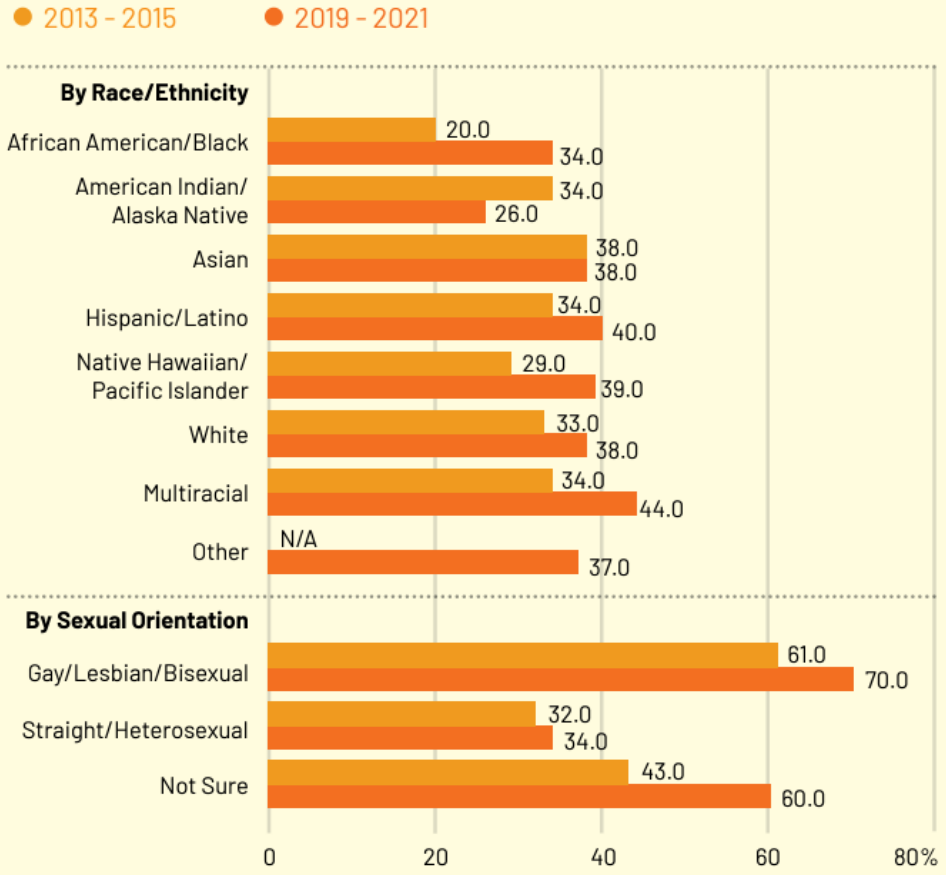
Behavioral Health

Percent Socially and Emotionally Vulnerable Kindergarteners, by Race/Ethnicity



11th Graders who Reported Experiencing Depression-Related Feelings



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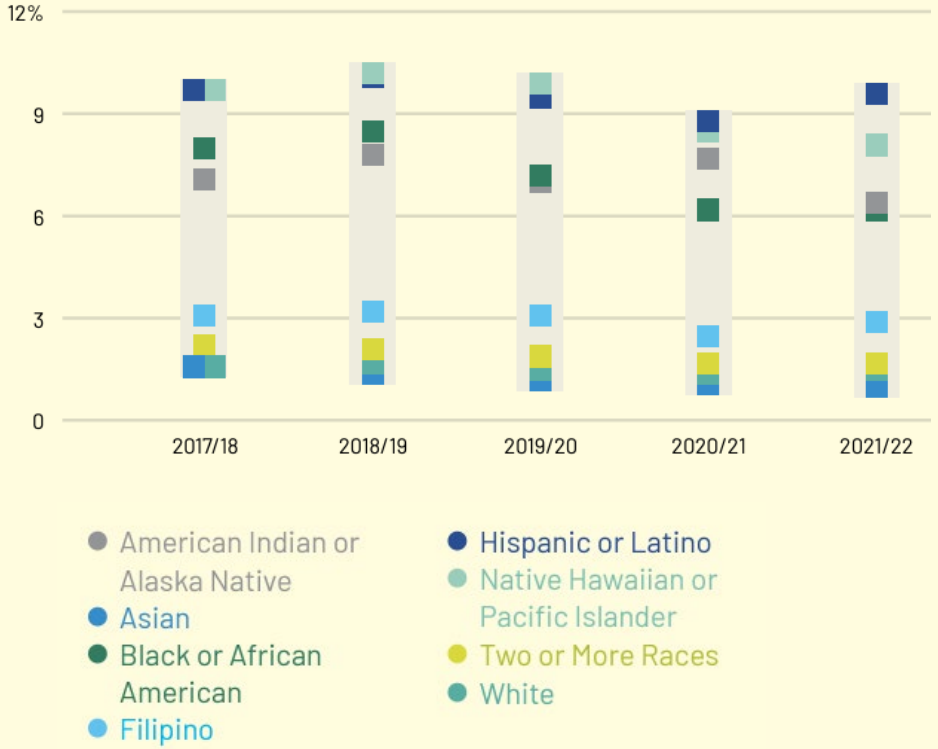
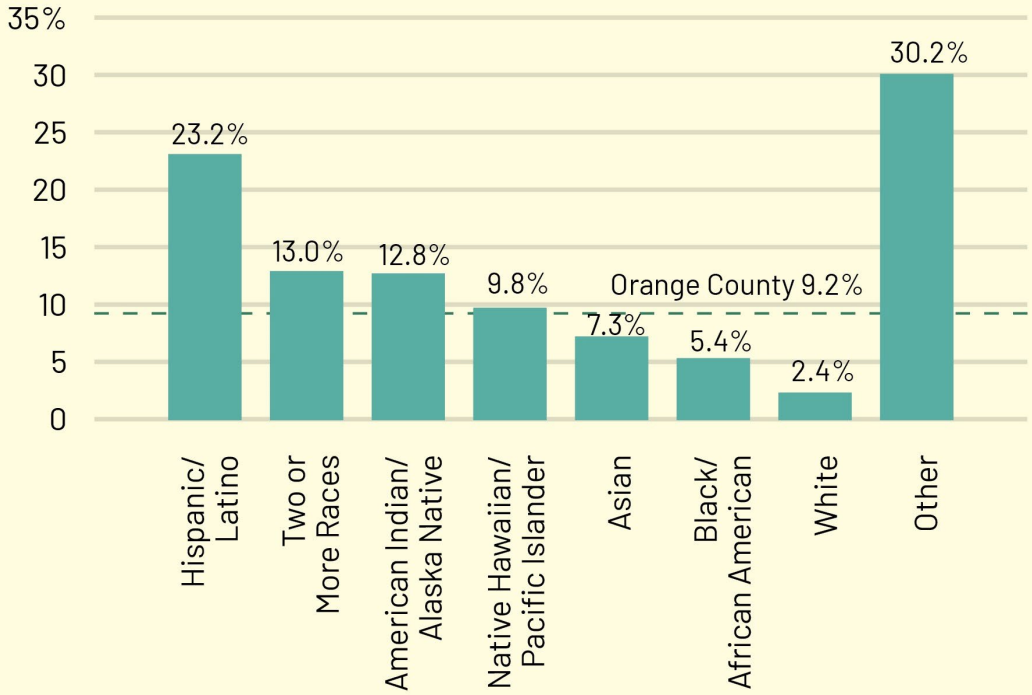
Housing Security

Percent of Enrolled Students with Insecure Housing, by Race/Ethnicity



Percent of Overcrowded Households, by Race/Ethnicity



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How can the community use the report…

- To identify improving or worsening trends over 10 years
- To better understand where there are disparities by race/ethnicity, age, geography, and other demographics
- To develop data-informed community solutions

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Other Community Forums

District 3

February 22nd at
Mission Hospital

District 4

March 22nd at
La Habra City Hall

Conditions of Children in Orange County Reports can be found online at:

https://ssa.ocgov.com/about-us/news-publications/occp/annual-report

MEMORANDUM

DATE:	January 26, 2024
TO:	CalOptima Health Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — February 1, 2024, 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. New Members Join Through Medi-Cal Expansion

As of January 1, a new law in California allows adults ages 26 through 49 to qualify for Medi-Cal regardless of immigration status. This latest expansion of Medi-Cal means that all Californians now have access to coverage; prior expansions extended coverage to undocumented children, young adults and people over 50. Individuals whose immigration status previously limited their access to full Medi-Cal were automatically transitioned from what's known as restricted Medi-Cal, which only covered them in emergencies. CalOptima Health's Customer Service department reports a steady influx of calls from our 48,430 newly enrolled Medi-Cal members. Our team is helping them with provider and health network selection and answering a variety of questions. Of the total number of new members, 38,180 (representing the majority at 79%) selected Spanish as their language preference. This will help inform our communications strategy of in-language outreach to potential new members in the community.

B. New Member Representative Joins Board

In December, the Orange County Board of Supervisors (BOS) appointed Maura Byron as CalOptima Health's newest Board member holding the Member Representative seat, which was vacated due to the resignation of Nancy Shivers, for an unexpired term ending August 3, 2024. Ms. Byron is the Executive Director of Family Support Network, an organization that provides resources and advocacy services for families of children with special needs so they may reach their full potential. In addition, her daughter is a current CalOptima Health member. Ms. Byron previously served as Chair of the CalOptima Health Member Advisory Committee.

C. Prime Healthcare's Hospital Contract Notice of Termination

On Friday, January 5, CalOptima Health sent out a Provider Alert (eNewsletter) to notify providers that CalOptima Health has issued a Notice to Terminate, without cause, our Medi-Cal and OneCare contracts with the following hospitals, effective February 5, 2024: Prime Healthcare Garden Grove, LLC dba Garden Grove Hospital Medical Center, Prime Healthcare Huntington Beach dba Huntington Beach Hospital, Prime Healthcare La Palma, LLC dba La Palma Intercommunity Hospital and Prime Healthcare Anaheim, LLC dba West Anaheim Medical Center.

Although these listed facilities will no longer be contracted at CalOptima Health plan rates they will receive payments for services at the state fee schedule for Medi-Cal. Of note is that this does not limit any access for any member for either emergency care, as protected under federal EMTALA rules, or other out-patient medical care. Per Department of Health Care Services (DHCS) requirements, members were sent notices as of January 5, 2024, after DHCS reviewed the letters and transition plan. If CalOptima Health providers have existing authorizations for services, we will work with them to coordinate and make sure that all medically necessary treatments for members are completed. CalOptima Health members will still have access to these Prime Healthcare hospitals for emergency room services and CalOptima Health maintains an adequate network of providers per state regulations.

Moreover, and to assure our members and providers, we have complied with all health plan Access, Notice, and Transition Requirements with our regulator, DHCS. We have reached out to our impacted provider and hospital partners to ensure Access and Transition care for our members. We have assigned designated Medical Directors for care coordination. We are working with our local city governments and community partners on Notice and Transition for the unhoused. CalOptima Health members had only ~50 elective inpatient visits over the past 12-months over the four Prime facilities, and they will be easily absorbed by our current network. We are not required and do not contract with all hospitals in Orange County. We are fortunate to have well-established networks of physicians, hospitals, clinics, skilled facilities, and other network providers and rely on their expertise in providing high quality managed care to our members.

D. Kelly Bruno-Nelson Appointed to Orange County Commission to End Homelessness

On January 23, the Orange County BOS unanimously appointed Kelly Bruno-Nelson, MSW, Executive Director, Medi-Cal/CalAIM, to the Orange County Commission to End Homelessness (Commission) for a two-year term, through January 22, 2026. At the recommendation of CalOptima Health, the BOS previously approved an amendment to the Commission Bylaws to add a voting member seat for a Medi-Cal Managed Care Health Plan Representative. Please see the press release here.

E. New Medical Management Platform Goes Live

CalOptima Health's new clinical documentation platform, known as Jiva, will go live on February 1. Jiva is expected to significantly enhance CalOptima Health's service to members through case management, utilization review, Grievance and Appeals Resolution Services and more.

F. MCO Tax Received Federal Approval

The Centers for Medicare & Medicaid Services (CMS) has approved the implementation of California's Managed Care Organization (MCO) tax, which was renewed as part of the FY 2023–24 Enacted State Budget, retroactively effective from April 1, 2023, through December 31, 2026. However, while the MCO tax met the standards for automatic approval, CMS cautioned that it appears to violate the spirit of the applicable federal regulations governing the drawdown of federal matching funds. Therefore, CMS will engage in a future rulemaking process that may impact the continuation of this and/or any future MCO taxes, such as the proposed November 2024 state ballot initiative that would permanently extend the MCO tax.

G. Governor Releases FY 2024–25 Proposed State Budget

On January 10, Gov. Gavin Newsom released his FY 2024–25 Proposed State Budget. With total spending at $291.5 billion ($208.7 billion General Fund [GF]), the governor estimates a $37.9 billion deficit — approximately half the projected $68 billion deficit previously reported by the Legislative

Analyst's Office. The governor attributes the shortfall to stock market (capital gains) revenue declines as well as last year's delay in income tax collection deadlines due to extreme weather conditions. To address the deficit and achieve a balanced budget, the governor proposes a combination of reserve withdrawals, loans, fund shifts, spending delays and some reductions. Since most reductions are in non-health care sectors, no significant negative impacts are expected for CalOptima Health at this time.

Specifically, the proposed Medi-Cal budget is $161.1 billion ($36.7 billion GF) with a projected average enrollment of 13.7 million beneficiaries — a decrease of 6.79% from the previous FY due to ongoing Medi-Cal redeterminations. In addition, the proposed budget includes the following provisions that may impact CalOptima Health members, providers and stakeholders:

- Fully funds all current and scheduled California Advancing and Innovating Medi-Cal (CalAIM) initiatives, including Transitional Rent services no sooner than January 1, 2026.
- Fully funds the recent expansion of full Medi-Cal eligibility to ages 26–49, regardless of immigration status, and the elimination of Medi-Cal asset limits, both effective January 1, 2024.
- Amends the MCO tax to increase revenues by an additional $1.5 billion to support the Medi-Cal program and maintain a balanced budget. Nearly all previously committed MCO tax investments remain fully funded.
- Adds a "trigger" to the phased-in minimum wage schedule for health care workers, recently enacted by Senate Bill 525, in order to condition annual increases on healthy budget levels.
- Reduces Proposition 56 supplemental payments for "physician services" by $193.4 million, but fully funds all other Proposition 56 supplemental payments. However, since the affected providers will also receive targeted rate increases from MCO tax revenues, this proposal is only expected to minimize those increases.
- Reverts $14.9 million in unexpended funds for the Clinic Workforce Stabilization & Retention Payment Program.
- Delays some funding for Behavioral Health Bridge Housing and the Behavioral Health Continuum Infrastructure Program from FY 2024–25 to FY 2025–26.
- Despite budget pullbacks, adds "wellness coaches" as a new Medi-Cal covered benefit, effective January 1, 2025, through the Children & Youth Behavioral Health Initiative (CYBHI).

Gov. Newsom's administration will continue to release further details in the coming weeks. In addition, the State Legislature will hold committee hearings to review the governor's proposals as well as consider its own proposals. Gov. Newsom will then release a revised budget proposal (May Revise) by May 14, which considers updated revenue projections. Finally, the governor and Legislature must negotiate and enact a final budget by July 1. Staff will work closely with legislators and stakeholders to advance CalOptima Health's priorities throughout the budget process.

H. New County Programs Approved for Vulnerable Populations

CalOptima Health welcomes the addition of two more programs to combat homelessness. Staff will work with county officials to ensure benefits are closely coordinated with CalOptima Health's CalAIM services, including Enhanced Care Management and Community Supports.

- **Homelessness Prevention and Stabilization Pilot Program:** The BOS unanimously approved a new Homelessness Prevention and Stabilization Pilot Program, introduced by Supervisor Vicente Sarmiento, which will combine homelessness prevention and robust case management aimed at promoting housing stability. Specifically, the program will provide short-term (no longer than 12 months) financial intervention to Orange County individuals and families at risk of homelessness or experiencing a housing crisis to cure rental arrears and past due utility bills, vehicle repairs, and

insurance payments as well as fund forward rent and/or utility bills based on financial need. At the same time, robust case management will focus on developing a financial stability plan and supportive services plan to identify community-based programs and resources that support the household in achieving long-term housing stability.

- **Emergency Rental Assistance Pilot Program:** The BOS unanimously approved Supervisor Doug Chaffee's Emergency Rental Assistance Pilot Program for residents of the Fourth District. Administered by the Friendly Center, which is based in Orange and Buena Park, the program will provide short-term rental assistance and wraparound services to prevent residents from losing tenancy as well as transition unhoused or temporarily housed residents into permanent housing. Funded through Fourth District discretionary funds, this program is separate from the countywide program described above.

I. CalOptima Health Leaders Volunteers for Point In Time Count

CalOptima Health's leaders were among community members who volunteered for the recent Point In Time (PIT) Count — a count and survey of people experiencing homelessness on a given night. The PIT Count provides vital information that helps Orange County and the Orange County Continuum of Care better understand homelessness in the community and guides the local response to homelessness.

J. Grant Applications for HHIP Projects Due Feb. 22

CalOptima Health released our Housing and Homelessness Incentive Program (HHIP) Round 3 Notice of Funding Opportunity (NOFO) and application on our website. The NOFO will fund equity grants, transitional housing and systems change projects, and closes on Thursday, February 22. Separately, in December 2023, CalOptima Health submitted our final report to DHCS about our HHIP work. We have participated in HHIP since it launched in April 2022 and expect to earn a total of $74.33 million of the available $83.78 million incentive dollars.

K. Workforce Development Initiative to Fund $10 Million in Grants

CalOptima Health has released the first Notice of Funding Opportunity (NOFO) of the Board-approved Workforce Development program. In this round, up to $10 million in grants are available to educational institutions offering programs that will increase the pipeline of future health care workers, including students going into the high-need areas of nursing, primary care (non-physician) and behavioral health. This funding is part of a five-year, $50 million Provider Workforce Development Strategic Initiative. Please see the press release here.

L. CalOptima Health Awards Community Health Worker Academy Capacity-Building Grants

To support the implementation of the Community Health Worker (CHW) Medi-Cal benefit in Orange County, CalOptima Health invited organizations to apply for Incentive Payment Program (IPP) CHW Academy Capacity-Building Grants. Organizations applied for up to $100,000 in capacity-building support, along with entrance into the six-month CHW Academy, which will prepare organizations to become contracted providers of CHW services for CalOptima Health. Up to 15 organizations will receive funding from April 2024 to March 2025.

M. CHOC and Rady Children's Hospital to Merge

Rady Children's Hospital and Children's Hospital of Orange County (CHOC) announced their intent to merge, pending regulatory approval from the state attorney general. A joint statement indicates that the two organizations believe that becoming one will help train and recruit talent and expand access to

pediatric care throughout Southern California and promote research. The two organizations will become Rady's Children's Health. At this time, there are no changes to our contract with CHOC or our members' access to services.

N. Optum Integration Project Completed

On January 1, 2024, Optum Care Network, Arta and Talbert consolidated their members and providers and are now known as Optum. Optum and CalOptima Health collaborated closely on this transition to ensure no disruption to members' care.

O. Annual Report to the Community Highlights Accomplishments

CalOptima Health mailed our annual Report to the Community to 1,000 stakeholders and community partners. The 48-page report highlights the impacts and accomplishments of the past year, working with the Board and our partners to achieve results and transform the delivery of care to our members. Special sections cover Access to Care, Community, Support Services, Preventive Care, Food and Housing, and Mental Well-Being. Readers can scan QR codes throughout to watch inspiring member videos, our brand campaign commercial and media coverage. Please see the report on our website here.

P. State Legislators Film Public Service Announcements on Medi-Cal Renewal

Recently, CalOptima Health partnered with several state legislators to produce public service announcements (PSAs) to help share the news about Medi-Cal renewal. We anticipate that the elected officials will feature the PSAs on their social media platforms to inform their constituents about necessary steps to renew their Medi-Cal coverage. So far, we have produced PSAs with introductions from Senator Tom Umberg, Assemblywoman Laurie Davies, Assemblywoman Cottie Petrie-Norris, Assemblywoman Sharon Quirk-Silva and Assemblyman Tri Ta.

Q. CalOptima Health Gains Media Coverage

Reflecting our ongoing innovation and program development, CalOptima Health received recent positive and valuable media coverage, including the following:

- On November 28, the Orange County Register ran a story on our grants for the construction of permanent housing units.
- On November 29, the Los Angeles Times/Daily Pilot published an opinion piece by Becks Heyhoe, executive director of United to End Homelessness, Orange County United Way, on the issue of homelessness and lauded CalOptima Health's Street Medicine Program.
- On December 6, Fierce Healthcare covered news about CalOptima Health's naloxone distribution efforts.
- On December 22, CEO Michael Hunn was listed in the Orange County Register among Orange County's 125 Most Influential People for 2023.
- On January 6, the Los Angeles Times/Daily Pilot ran an article on our Street Medicine Program expansion in Costa Mesa. The article includes an interview with Executive Director of Medi-Cal/CalAIM Kelly Bruno-Nelson.
- On January 10, the Orange County Register ran an article on CalOptima Health's first phase of grants in the $50 million, five-year Provider Workforce Development Initiative.

CalOptima Health

Fast Facts
February 2024

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

Membership Data* (as of December 31, 2023)

Total CalOptima Health Membership

954,214

Program	Members
Medi-Cal	936,174
OneCare (HMO D-SNP)	17,593
Program of All-Inclusive Care for the Elderly (PACE)	447

*Based on unaudited financial report and includes prior period adjustment

Operating Budget (for six months ended December 31, 2023)

	YTD Actual	YTD Budget	Difference
Revenues	$2,368,868,998	$2,088,838,607	$280,030,391
Medical Expenses	$2,183,823,010	$1,954,368,555	($229,454,455)
Administrative Expenses	$109,061,671	$124,195,589	$15,133,918
Operating Margin	$75,984,318	$10,274,463	$65,709,855
Medical Loss Ratio (MLR)	92.2%	93.6 %	(1.4%)
Administrative Loss Ratio (ALR)	4.6%	5.9%	1.3%

Note: Totals may not add due to rounding

Reserve Summary (as of December 31, 2023)

	Amount (in millions)
Board Designated Reserves	$629.3*
Capital Assets (Net of depreciation)	$94.3
Resources Committed by the Board	$606.9
Resources Unallocated/Unassigned	$478.9*
Total Net Assets	$1,809.3

Total of Board-designated reserves and unallocated resources can support approximately 95 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.

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CalOptima Health Fast Facts

February 2024

Personnel Summary (as of January 13, 2024, pay period)

	Filled	Open	Vacancy % Medical	Vacancy % Administrative	Vacancy % Combined
Staff	1,304.5	91.4	46.63%	53.37%	6.54%
Supervisor	76	6	66.67%	33.33%	7.32%
Manager	112	10	40%	60%	8.20%
Director	61	4.5	44.44%	55.56%	6.87%
Executive	20	2	--- %	100%	9.09%
Total FTE Count	1,573.5	113.9	43.81%	56.19%	6.75%

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

Provider Network Data (as of December 31, 2023)

	Number of Providers
Primary Care Providers	1,247
Specialists	9,153
Pharmacies	553
Acute and Rehab Hospitals	43
Community Health Centers	52
Long-Term Care Facilities	107

Treatment Authorizations (as of November 30, 2023)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	9.84 hours
Prior Authorization – Urgent	72 hours	21.16 hours
Prior Authorization – Routine	5 days	2.20 days

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

Member Demographics (as of December 31, 2023)

Member Age	
0 to 5	8%
6 to 18	25%
19 to 44	34%
45 to 64	20%
65 +	13%

Language Preference	
English	58%
Spanish	27%
Vietnamese	9%
Other	2%
Korean	2%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	39%
Expansion	37%
Optional Targeted Low-Income Children	8%
Seniors	10%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

December 7, 2023

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on December 7, 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. The meeting recording is available on CalOptima Health's website under Past Meeting Materials. Chair Corwin called the meeting to order at 2:07 p.m., and Director Norma García Guillén led the Pledge of Allegiance.

ROLL CALL

Members Present: Clayton Corwin, Chair; Blair Contratto, Vice Chair; Debra Baetz (non-voting); Isabel Becerra; Supervisor Doug Chaffee; Norma García Guillén; Jose Mayorga, M.D.; Supervisor Vicente Sarmiento (at 2:08 p.m.); Trieu Tran, M.D. (at 2:11 p.m.)

(All Board members in attendance participated in person)

Members Absent: None

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

The Clerk noted for the record that Agenda Item 7 was continued for further study and will be brought back to a future Board meeting for consideration.

PRESENTATIONS/INTRODUCTIONS

1. Homeless Housing Incentive Program Grantee Awards

Kelly Bruno-Nelson, Executive Director, CalAIM and Medi-Cal, introduced this item, noting that in October 2023, CalOptima Health awarded $52.3 million in community grants to fund 15 affordable and permanent supportive housing projects across the county. These community investments were made possible through earnings from the California Department of Health Care Services Housing and Homeless Incentive Program (HHIP), as well as Board-directed matching funds. CalOptima Health introduced the Board to five of these wonderful organizations and conducted check presentations as a symbol of its commitment to their work.

First, the Anaheim Housing Authority was granted $3.8 million to support the development of 87 permanent supportive housing units. Through a state home key grant, the Housing Authority was able to acquire the North Harbor apartments. This property, currently serving as a non-congregate shelter, will now transition into permanent supportive housing.

The second grantee, Families Forward, was granted $2.5 million to acquire a parcel of land in Tustin to build eight affordable housing units for families with children who are unhoused or at risk of becoming unhoused. Site plans have already been drafted and construction is expected to begin soon.

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The third grantee, Community Development Partners, was awarded the largest amount possible through this opportunity of $8 million. Their project will provide 87 affordable housing units in the city of Costa Mesa to extremely low-income veterans, individuals with serious mental illness, and seniors.

The fourth grantee, Jamboree Housing, was awarded $4.77 million to convert an existing motel in Santa Ana into 89 permanent supportive housing units. These units will be earmarked for veterans and people experiencing homelessness.

Finally, the fifth grantee, Mercy House California, was awarded $1.5 million to make available 50 affordable housing units in the city of Orange. The project converts the former convent of the Sisters of St. Joseph of Orange into affordable housing apartments with 18 of the 50 units being reserved for formerly unhoused seniors.

Ms. Bruno-Nelson shared that all grantees have expressed immense gratitude for CalOptima Health's support of their projects. She also thanked the CalOptima Health Board for being a consistent champion for these important investments throughout Orange County and for believing that housing is health.

2. CalOptima Health Recognition – Brigette Hoey, Chief Human Resources Officer
Michael Hunn, Chief Executive Officer, recognized Brigette Hoey, Chief Human Resources Officer, who plans to retire in January 2024, for her years of service to CalOptima Health and the members it serves. He noted her many accomplishments in helping hire and retain employees dedicated to CalOptima Health's mission and vision.

CalOptima Health's Board members thanked Ms. Hoey for her service.

Ms. Hoey thanked Mr. Hunn and the Board for their kind words and noted it has been a privilege to serve and thanked them for their support of CalOptima Health's members and its employees.

MANAGEMENT REPORTS

3. Chief Executive Officer Report
Mr. Hunn started his report by offering everyone the very best wishes for a happy holiday during this season of light for all families. CalOptima Health hopes that this season brings great joy and happiness to many, and certainly to its Board members and their families and all its staff and their families.

Mr. Hunn reviewed the Fast Facts data and reported that CalOptima Health currently serves about 970,000 individuals. CalOptima Health spends 91.4% of every dollar on medical care, and 4.4% is the overhead cost to administer the program.

CalOptima Health's Board-designated reserves are $613.9 million; its capital assets are $92 million; its resources committed by the Board are $622.9 million; and its unallocated and unassigned resources are $439.0 million. Mr. Hunn noted that CalOptima Health's total net assets are currently $1.7 billion.

Mr. Hunn also reviewed the CalOptima Health personnel data and noted that there are about 1,600 employees with a vacancy/turnover rate of about 8.68% as of the November 18, 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 10,310 providers, 1,260 primary care providers, and 9,053 specialists; 553 pharmacies; 44 acute and rehab hospitals; 52

community health centers; and 107 long term care facilities.

Mr. Hunn reviewed CalOptima Health's treatment authorizations, noting that the data is as of September 30, 2023. For urgent inpatient treatment authorizations, the average approval is within 11.41 hours; the state-mandated response is 72 hours. For urgent prior authorizations, the average approval is within 14.89 hours; the state-mandated response is 72 hours. And for routine prior authorizations, the average approval is 1.64 days; the state-mandated response is 5 days.

Mr. Hunn updated the Board on redetermination, also known as Medi-Cal Renewal, and the transition of CalOptima Health members served by Kaiser Permanente (Kaiser) transitioning to direct service through Kaiser. He also thanked the Board for their support at various events, including a presentation regarding Medi-Cal renewal at the Placentia City Council.

Mr. Hunn updated the Board on CalOptima Health's six-month update to the auditors regarding the California State Audit (CSA). He noted that the full update will be posted on CalOptima Health's website following its submission to CSA.

In addition to several other updates, Mr. Hunn also provided an update on CalOptima Health's first Naloxone Community Event, which was held on December 2, 2023. He noted that there were about 150 individuals in attendance, and CalOptima Health distributed about 488 doses of Naloxone. Mr. Hunn thanked Supervisor Sarmiento for attending and presenting in Spanish and noted that one of CalOptima Health's medical directors provided translation in Vietnamese.

Dr. Michaell Rose, Chief Health Equity Officer, also attended the event and had the privilege of speaking to some of the participants during and after the event. Dr. Rose noted that participants expressed their desire for more education and awareness regarding the dangers of fentanyl and suggested that future Naloxone distribution events could be at community and resources centers, parks, community colleges, schools, and places of worship. She added that participants at this event were eager to partner with CalOptima Health and agreed to share the information from the event with others. Dr. Rose then translated what she shared with the Board into Spanish for any Spanish-speaking individuals who may be listening so they will know that she was listening to what they said and that they were heard.

After providing several other updates, Mr. Hunn responded to Board member comments and questions.

PUBLIC COMMENTS

- Thary Sok, Community Member: Oral regarding need for mental health services in member's language and for providers to allot additional time for appointments.

Mr. Hunn thanked the community member, and the translator, for their comments and apologized to the member who did not have access to a translator during her recent appointment. He noted that CalOptima Health takes these issues very seriously and will follow up appropriately regarding the past visit and to ensure that a translator is available at the member's next appointment and going forward. Mr. Hunn noted that CalOptima Health will work to ensure there are processes in place with technologies available to provide for CalOptima Health's multilingual population.

CONSENT CALENDAR

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4. Minutes

a. Approve Minutes of the November 2, 2023 Regular Meeting of the CalOptima Health Board of Directors
b. Receive and File Minutes of the September 21, 2023 Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee

Supervisor Chaffee noted that he did not want to pull anything from the Consent Calendar but wanted to comment that in the minutes from the November 2, 2023, Board meeting, which he did not attend, he noted that under Agenda Item 11 from that meeting there was a recommendation by Director Mayorga to change the Board officer elections from fiscal year to calendar year. Supervisor Chaffee said he did not see that change noted in the minutes and was inquiring if the recommendation was addressed.

James Novello, Outside General Counsel, responded that the CalOptima Health Board elections are held at the organizational meeting, which was set for June 2023. Any change to that election schedule would require a change to the organizational meeting date through an amendment, which did not occur. Mr. Novello noted that if there is a desire to change the election, it would need to be made through a separate agenda item for the Board to discuss.

Vice Chair Contratto added that the Board did discuss this at the Governance Ad Hoc Committee (Ad Hoc Committee) and because almost all Board seats are up for possible reappointment with terms ending in August 2024, the Ad Hoc Committee members thought that waiting until after the possible reappointments would be better in case a Board member is elected to serve as Chair or Vice Chair but does not end up getting reappointed. The Ad Hoc Committee felt a shorter period for this election of officers would be better due to this unusual situation.

5. Authorize and Direct Execution of CalOptima Health's New Primary and Secondary Agreements with the California Department of Health Care Services

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

7. Approve Modifications to CalOptima Health Policy GA.5002: Purchasing

This item was continued to a future meeting.

8. Approve Modifications to CalOptima Health Policy GA.3400: Annual Investments

9. Approve Modifications to CalOptima Health PACE Policy PA. 6001 Medical Records Maintenance

10. Approve Updates to the CalOptima Health Provider Dispute Resolution Process effective January 1, 2024, and Impacted Policies MA.9006, MA.9009, HH.1101, FF.2001 and MA.3101

Supervisor Sarmiento thanked staff for the update on the dispute resolution process for CalOptima Health providers which will lead to greater support and efficiencies for providers.

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11. Adopt Resolution No. 23-1207-03 Declaring CalOptima Health Employee Handbook as a Guideline Document and Adopt Resolution No. 23-1207-04 Approving and Adopting Updated CalOptima Health Human Resources Policies

12. Adopt Resolution No. 23-1207-02 Authorizing the Adoption of the Public Agency Retirement Services (PARS) Trust Agreement and the Appointment of a Plan Administrator

13. Authorize Utilization of a Customized Contract

14. Approve Reappointment to the CalOptima Health Board of Directors' Investment Advisory Committee

15. Authorize Actions Related to the mPulse Vendor Contract

16. Ratify and Authorize Actions Related to the Contract of a Managed Security Service Provider (MSSP) to Manage the LogRhythm Security Incident and Event Monitoring (SIEM) System

17. Ratify and Authorize Actions Related to the Purchase and Upgrade of the Existing LogRhythm Appliance and Additional Capacity License

18. Adopt Resolution No 23-1207-01 to Add Two Additional Seats and Rename One Seat on the CalOptima Health Board of Directors' Member Advisory Committee

19. Receive and File: CalOptima Health Community Outreach and Program Summary

20. Receive and File:
    a. October 2023 Financial Summary
    b. Compliance Report
    c. Federal and State Legislative Advocates Reports

Supervisor Sarmiento commented for the record on Agenda Item 20.c., CalOptima Health's Federal and State Legislative Report. Supervisor Sarmiento wanted CalOptima Health's Board members to know that at the Board of Supervisors meeting on December 5, 2023, he had mentioned during a discussion of legislative priorities at the County that one of the items had to do with rental assistance to those who are unhoused. Supervisor Sarmiento added that the County is looking to see if that language can be amended to include not only those who are unhoused, but to also include those who are on the verge of becoming unhoused. Supervisor Sarmiento added that he appreciates the alignment of CalOptima Health and the County on many of these legislative initiatives.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 4 through 20, minus Agenda Item 7, which was continued to a future meeting, as presented, with comments noted above. (Motion carried; 8-0-0)***

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REPORTS/DISCUSSION ITEMS

21. Authorize Adult Expansion Outreach Strategy to Make Eligible Adults Ages 26 Through 49 Aware of the Opportunity to Apply for Full-Scope Medi-Cal Regardless of Immigration Status

Deanne Thompson, Executive Director, Marketing and Communications, introduced this item.

Director Becerra underscored the fact that anyone living in the shadows can now feel safe to access care without repercussions, and Vice Chair Contratto gave a shout out to Ms. Thompson and Mr. Hunn on CalOptima Health's rebranding and outreach efforts.

After a robust discussion, the Board approved the following amended motion:

Action: ***On motion of Director Mayorga, seconded and carried, the Board of Directors: 1.) Authorized implementation of an Adult Expansion Outreach Strategy to promote enrollment of eligible adults ages 26-49 into full-scope Medi-Cal, regardless of immigration status; 2.) Authorized unbudgeted expenditures and appropriated up to ~~$2,500,000~~ $5,000,000 from existing reserves to implement the Adult Expansion Outreach Strategy; and 3.) Authorized the Chief Executive Officer to execute agreements for expenditures as necessary to implement proposed activities. (Motion carried; 8-0-0)*** *Rev. 12/07/2023*

22. Approve Actions Related to the Workforce Development Strategic Priority

Yunkyung Kim, Chief Operating Officer, introduced this item.

Action: ***On motion of Vice Chair Contratto, seconded and carried, the Board of Directors: 1.) Approved the proposed program pillars for Provider Workforce Development initiative as: a.) Educational Investments to Increase Supply of Health Care Professionals; b.) Workforce Training & Development Innovation Fund; c.) Physician Recruitment Incentive Program; d. Physician Loan Repayment Program; e.) Orange County Health Care Workforce Development Collaborative; 2.) Authorized the Chief Executive Officer, or designee, to issue an initial notice of funding opportunity for Educational Investments to Increase Supply of Health Care Professionals; 3.) Authorized from the $50 million restricted CalOptima Health Provider Workforce Development Fund an allocation of up to $10 million to fund the grant agreements; and 4.) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose. (Motion carried; 8-0-0)***

23. Authorize a Contract with Behavioral Health Virtual Visits Vendor

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors: 1.) Executed a contract with TeleMed2U to provide virtual behavioral health (BH) care services for all CalOptima Health Medi-Cal and OneCare members (except Kaiser and PACE). The contract is to be effective April 1, 2024, for a three (3) year term with two (2) additional***

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one-year extension options, each exercisable at CalOptima Health's sole discretion; and 2.) Allocated up to $2.7 million to fund this engagement through June 30, 2024.: (Motion carried;8-0-0)

24. Approve CalOptima Health Measurement Year 2024 and Modification to Measurement Year 2023 Medi-Cal and OneCare Pay-for-Value Programs

Director Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers. Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health.

Ms. Kim introduced this item.

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors: 1.) Approved Measurement Year 2024 Medi-Cal Pay for Value Performance Program for the measurement period effective January 1, 2024, through December 31, 2024; 2.) Approved Measurement Year 2024 OneCare Pay for Value Performance Program for the measurement period effective January 1, 2024, through December 31, 2024; 3.) Approved the use of unearned Measurement Year 2023 and 2024 Pay for Value Performance Program funds for quality initiatives and grants; and 4.) Authorized unbudgeted expenditures in an amount up to $23.3 million from existing reserves to fund Measurement Year 2023 unearned incentive payments for quality initiatives and grants. (Motion carried; 6-0-0; Directors Becerra and Mayorga recused)***

25. Approve Actions Related to the Housing and Homelessness Incentive Program for Transitional Housing

Director Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers.

Kelly Bruno-Nelson, Executive Director, Medi-Cal and CalAIM, introduced this item.

Director Sarmiento thanked staff and the city of Anaheim for their efforts in that city in partnership with CalOptima Health and the County. He noted that two checks were delivered to the city of Anaheim for the development and rehabilitation of approximately 189 units. Supervisor Sarmiento added that the city of Anaheim and others have stepped up and realized the value of having these units and the investment introduced in their community. He noted that about 1100 units have been realized through the Housing and Homeless Incentive Program (HHIP).

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors: 1.) Appropriated up to $25 million from existing reserves to provide additional support for Housing and Homeless Incentive Program (HHIP) Priority 3: Partnerships and capacity to support referrals for services, which includes capital projects; 2.) Authorized CalOptima Health staff to develop a scope of work to be used in a notice of funding opportunity for transitional housing programs as a focus of Priority 3.; 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 Becerra recused)

26. Approve Actions Related to the Incentive Payment Program for Community Health Worker Academy

Director Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Authorized CalOptima Health staff to conduct a notice of funding opportunity (NOFO) process related to the Community Health Worker (CHW) Academy, administer grant agreements, and release award payments to up to 20 selected entities in an amount of up to $100,000 per grantee: a.) Up to five current contracted providers of CHW services (as of January 1, 2024); and b.) Up to 15 organizations with expertise in CHW services that are not yet contracted with CalOptima Health; 2.) Approved allocation of up to $2 million in Incentive Payment Program (IPP) funds for Program Year (PY) 1 for the Delivery System Infrastructure IPP priority area to provide capacity building support to CHW Academy participants. (Motion carried; 7-0-0; Director Becerra recused)***

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

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors: 1.) Approved the Notice of Interest Opportunity Evaluation Committee recommendation for two additional host-cities for the expansion of CalOptima Health's Street Medicine Program. (Motion carried; 8-0-0)***

28. Approve Actions Related to the Homeless Clinic Access Program

Director Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers.

Action: ***On motion of Vice Chair Contratto, seconded and carried, the Board of Directors: 1.) Approved CalOptima Health staff recommendations to administer two-year grant agreements and award payments to selected grant recipients (listed in Attachment 1) for the Homeless Clinic Access Program (HCAP); a.) Federally Qualified Health Centers (FQHC) and Community Health Centers (CHC) will provide health care services to all individuals experiencing homelessness, regardless of CalOptima Health membership through mobile unit or onsite medical room; i.) Total of payments recommended for clinics: $1,000,000 over two years totaling $2,000,000; b.) Orange County shelter operators will provide support to partnered FQHC and CHC; i.) Total of payments recommended for shelters: $500,000 over two years totaling $1,000,000; and 2.) Made a finding that such expenditures are for a public purpose and in***

furtherance of CalOptima Health's mission and purpose. (Motion carried; 7-0-0; Director Becerra recused)

29. Approve Amendment to Extend CalOptima Health Public Health Services Contract with the County of Orange and Add Provisions for New CalAIM Services

Supervisors Chaffee and Sarmiento did not participate in this item due to their role as Supervisors on the Orange County Board of Supervisors for the County of Orange.

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors Authorized the Chief Executive Officer (CEO) to execute an amendment to CalOptima Health's Coordination and Provision of Public Health Care Services Contract with the Orange County Health Care Agency (County), to: 1.) Extend the contract term through December 31, 2026; 2.) Add provisions reflecting the addition of the following two new community supports services under the California Advancing and Innovating Medi-Cal (CalAIM) program, effective January 1, 2024: a.) Community/Nursing Facility Transition to a Home Service; and b.) Nursing Facility Transition/Diversion Services; and 3.) Approved addition of Exhibit E, Business Associate Agreement (BAA). (Motion carried; 6-0-0; Supervisors Chaffee and Sarmiento recused)***

30. Approve Use of New MOU Templates Mandated by the Department of Health Care Services

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors Authorized CalOptima Health Contracting staff to implement eight (8) standardized Department of Health Care Services (DHCS) Memorandum of Understanding (MOU) templates, effective January 1, 2024. (Motion carried; 8-0-0)***

31. Approve Contract Amendments to CalOptima Health Fee-for-Service Professional Services and Ancillary Services Provider Contracts, for Cyber Liability Insurance Requirements, and Ownership and Disclosure Requirements

Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health. Supervisor Sarmiento did not participate in this item in an abundance of caution due to possible campaign contributions under the Levine Act. Director Tran did not participate in this item due to his role as a physician specialist serving CalOptima Health members.

Action: ***On motion of Chair Corwin, seconded and carried, the Board of Directors 1). Authorized the Chief Executive Officer to execute an amendment to the CalOptima Health Medi-Cal FFS Professional contracts to comply with DHCS requirements for Medi-Cal ownership and control disclosures in accordance with DHCS APL 23-006 and 42 CFR § 455.104, effective January 1, 2024; 2.) Authorized the Chief Executive Officer to execute an amendment to the CalOptima Health Medi-Cal and OneCare FFS Professional contracts to reflect requirements for cyber security insurance coverage of $1,000,000 per occurrence/claim, and $1,000,000 aggregate, effective January 1, 2024; 3.) Authorized the Chief Executive Officer to execute an amendment to***

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the CalOptima Health Medi-Cal and OneCare FFS Ancillary Services contracts to reflect requirements for cyber security insurance coverage of $1,000,000 per occurrence/claim, and $1,000,000 aggregate, effective January 1, 2024; and 4.) Amended Medi-Cal FFS Ancillary Services contracts to comply with DHCS requirements for Medi-Cal ownership & control disclosures in accordance with DHCS APL 23-006 and 42 CFR § 455.104. (Motion carried; 5-0-0; Director Mayorga, Supervisor Sarmiento, and Director Tran recused)

32. Approve Contract Amendments for CalOptima Medi-Cal Health Network Providers Reflecting Cyber Liability Insurance Requirements, New Hospital Referral Procedures, Ownership and Disclosure Requirements, and Pay for Value Performance Program Incentive Payment Requirements

Director Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers. Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health. Director Tran did not participate in this item due to his role as a physician specialist serving CalOptima Health members.

Action: ***On motion of Chair Corwin, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer to execute an amendment to the CalOptima Health Medi-Cal Shared-Risk Group (SRG), Health Maintenance Organization (HMO), and Physician-Hospital Consortia (PHC) health network contracts to reflect requirements for cyber security insurance coverage of $5,000,000 per occurrence/claim, and $5,000,000 aggregate, effective January 1, 2024; 2.) Authorized the Chief Executive Officer to execute an amendment to the CalOptima Health Medi-Cal SRG health network contracts to reflect requirements to refer CalOptima Members to providers that have hospital privileges at CalOptima Health contracted hospitals, effective January 1, 2024; 3.) Authorized the Chief Executive Officer to execute an amendment to the CalOptima Health Medi-Cal SRG, HMO and PHC health Network contracts to comply with DHCS requirements for Medi-Cal ownership and control disclosures in accordance with DHCS APL 23-006 and 42 CFR § 455.104, effective January 1, 2024; and 4.) Authorized the Chief Executive Officer to execute an amendment to the CalOptima Health Medi-Cal SRG, HMO, PHC Health Network contracts to distribute 85% of incentive payments passed down through the CalOptima Health Medi-Cal Pay for Value Performance Program (P4V Program) to contracted physicians, beginning with Measurement Year 2024. (Motion carried; 5-0-0; Directors Becerra, Mayorga and Tran recused)***

33. Authorize Amendment to CalOptima Health Medi-Cal Fee-for-Service Contract for Long Term Care Facility Services with Alta Newport Hospital, Inc, dba Foothill Regional Medical Center

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Action: ***On motion of Vice Chair Contratto, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer (CEO) to execute an amendment to CalOptima Health's Contract for Long Term Care Facility Services (Contract) with Alta Newport Hospital, Inc., dba Foothill Regional Medical Center (Foothill Regional) to increase reimbursement rates from 136% to 142% of the CalOptima Health Medi-Cal Fee Schedule, effective January 1, 2024; and 2.) Authorized unbudgeted expenditures and appropriated funds in an amount up to $350,000 from existing reserves to fund the increased reimbursement rates for the six-month period of January 1, 2024, through June 30, 2024. (Motion carried; 8-0-0)***

34. Adopt CalOptima Health Board of Directors' Rules of Procedure

Action: ***On motion of Vice Chair Contratto, seconded and carried, the Board of Directors Adopted Rosenberg's Rules of Order as the CalOptima Health's Board Rules of Procedure. (Motion carried; 8-0-0)***

35. Election of Officers of the CalOptima Health Board of Directors for Fiscal Year 2023-24
After considerable discussion, the Board opted not to use the process outlined in the Election of Officers policy for this election and took the following actions:

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors Elected Clayton Corwin to service as the Chair of the CalOptima Health Board of Directors effective December 7, 2023 through June 30, 2024, or until the election of a successor, unless the Board Chair shall sooner resign or be removed from office. (Motion carried; 8-0-0)***

Action: ***On motion of Chair Corwin, seconded and carried, the Board of Directors Elected Isabel Becerra to service as the Vice Chair of the CalOptima Health Board of Directors effective December 7, 2023 through June 30, 2024, or until the election of a successor, unless the Board Vice Chair shall sooner resign or be removed from office. (Motion carried; 8-0-0)***

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS
The Board congratulated Clayton Corwin and Isabel Becerra on their elections to Chair and Vice Chair through June 30, 2024. The Board also wished everyone happy holidays.

Director Contratto then generally directed staff to survey Board members on their interests for the CalOptima Health Board and also suggested that the Board convene for an all-day strategic planning session or possibly extend a Board meeting to allow for strategic planning discussions.

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ADJOURNMENT

Hearing no further business, Chair Corwin adjourned the meeting at 4:28 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: February 1, 2024

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

October 17, 2023

A Special Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee (Committee) was held on October 17, 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. The meeting recording is available on CalOptima Health's website under Past Meeting Materials.

Chair Trieu Tran called the meeting to order at 3:01 p.m. and led the Pledge of Allegiance.

CALL TO ORDER

Members Present: Trieu Tran, M.D., Chair; José Mayorga, M.D.
(All Committee members participated in person)

Members Absent: None

Others Present: Yunkyung Kim, Chief Operating Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Linda Lee, Executive Director, Quality Improvement; Monica Macias, Director, PACE; Sharon Dwiers, Clerk of the Board

MANAGEMENT REPORTS

1. Chief Medical Officer Report

Richard Pitts, D.O., Ph.D., Chief Medical Officer, reviewed the Chief Medical Officer Report with the Committee and started off by providing an update on the Jiva project. Dr. Pitts noted that Jiva will replace CalOptima Health's care management program, Guiding Care, which tracks everything to do with a member's health care. Dr. Pitts also noted that the transition is a heavy lift for the organization and touches most departments. The target date for Jiva to go live is February 1, 2024. The new Jiva system will streamline the interface for accessing current data on members' health care, from authorizations and case management to everything in between.

Dr. Pitts also provided an update on the Department of Health Care Services (DHCS) Population Health Managed Transitional Care Services. Dr. Pitts noted that this is an effort by the DHCS to improve the level of management of members anytime there is a transition of care. He explained that many managed care plans pushed back on the huge lift and staff intensity that would be required to undertake the DHCS' original request and have asked the state for a more realistic goal.

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Dr. Pitts also provided updates on the Street Medicine Program and the work that CalOptima Health and its community partners are collaborating on to ensure all members receive access to quality health care.

Dr. Pitts and Yunkyung Kim, Chief Operating Officer, responded to Committee member questions and comments.

PUBLIC COMMENTS
There were no requests for public comment.

CONSENT CALENDAR
2. Approve the Minutes of the June 14, 2023, Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

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

REPORTS/DISCUSSION ITEMS
3. Recommend that the Board of Directors Approve CalOptima Health's Calendar Year 2024 Member Health Rewards
Linda Lee, Executive Director, Quality Improvement introduced this item.

Action: ***On motion of Director Mayorga, seconded and carried, the Committee recommended that the Board of Directors: 1.) Approve CalOptima Health's Calendar Year 2024 Member Health Rewards for Medi-Cal and OneCare. (Motion carried 2-0-0)***

4. Recommend that the Board of Directors Approve CalOptima Health Measurement Year 2024 and Modification to Measurement Year 2023 Medi-Cal and OneCare Pay-for-Value Programs
Chair Tran noted for the record that he would not be participating in this item due to his role as a physician specialist serving CalOptima Health members and Director Mayorga would not be participating in this item due to his role as Executive Director, UC Irvine Health.

Linda Lee, Executive Director, Quality Improvement, introduced the item, noting that this would be for informational purposes for the Committee and members of the public because the item did not achieve a quorum due to recusals. Ms. Lee also noted that this would be presented to the full Board of Directors for discussion and consideration.

Ms. Lee noted that CalOptima Health re-analyzed its historical pay-for-value program to determine if the program was achieving its goals and was aligned with its mission and values. In the process of evaluating the pay-for-value program, CalOptima Health adopted the following principles to ensure that its pay-for-value program aligns with the program goals: CalOptima Health opted to use industry standard measures for each of its lines of business – for Medi-Cal it is using the DHCS Medi-Cal Accountability Set and for OneCare it is using the Centers for Medicare & Medicaid Services (CMS) Star measures. Ms. Lee added that CalOptima Health also sought to align its benchmarks with the federal and state government programs, so with the Medi-Cal program, the minimum performance level (MPL) is established at the 50th percentile, which is the same MPL the that the state holds

CalOptima Health to today. If CalOptima Health's scores fall below the MPL, it is subject to sanction and corrective action. In that case no health network should earn incentives for a measure that did not meet the MPL, and CalOptima Health would consider passing down any sanctions received to the health networks. Ms. Lee noted that CalOptima Health will also align with the DHCS's quality withhold program. DHCS is developing a withhold program that is slated to start January 1, 2024, where DHCS will withhold 5% of capitation payment from Medicaid managed care plans subject to the plans achieving quality performance benchmarks, however, the details of this program are not yet finalized. CalOptima Health's OneCare program benchmarks will align with the CMS Star thresholds, which is what Medicare Advantage plans across the country are held to. Ms. Lee noted that these principles would mean that networks that fall below the MPL would be subject to corrective action and no contracted health networks would earn an incentive for a measure that CalOptima Health is below the MPL. CalOptima Health is proposing that leftover dollars, either through forfeiture or unearned dollars due to networks not achieving higher benchmarks, be made available to the health networks in the form of grants. These grants could be used for quality improvement initiatives; health networks would apply; CalOptima Health would review and disseminate grants to health networks that choose to implement those quality initiatives; and CalOptima Health could also use those funds for delivery of system wide interventions.

Ms. Lee reviewed additional details regarding the updated pay-for-performance program.

No Action Taken: Item will be considered at the November 2, 2023, Board of Directors meeting.

INFORMATION ITEMS

5. Update on Assessment of Quality

Ms. Lee reported that at the beginning of the year, CalOptima Health conducted a quality assessment of the quality operations within CalOptima Health at that time. She noted that staff committed to coming back to the Board of Directors with periodic updates on progress made on risk areas or high priority items. Ms. Lee provided an update on the status of CalOptima Health's National Committee for Quality Assurance (NCQA) health plan accreditation and its credentialing assessment. For the NCQA accreditation, Ms. Lee noted that CalOptima Health maintained its four-star rating and is among the highest rated Medi-Cal plans in California. She also reviewed the key milestones and areas where CalOptima Health is strong and doing well and the areas where more work is being done to bring up CalOptima Health's ratings. Ms. Lee reviewed additional details, including the CalOptima Health credentialing assessment, and noted that staff is working internally and with its health networks and providers to ensure CalOptima Health is compliant and continues to improve the quality outcomes for its members.

Ms. Lee responded to Committee member questions and comments.

6. Initial Health Appointment Update

This item was accepted as presented.

7. Student Behavioral Health Incentive Program Update

This item was accepted as presented.

8. Skilled Nursing Facility Incentive Program Update

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This item was presented during the Chief Medical Officer's Report at the top of the meeting.

9. Whole-Child Model Family Advisory Committee Update
This item was accepted as presented.

10. Program of All-Inclusive Care for the Elderly Member Advisory Committee Update
Monica Macias, Director, CalOptima Health PACE Program, provided an update on the recent activities of the PACE Member Advisory Committee.

The following items were accepted as presented.

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

COMMITTEE MEMBER COMMENTS
The Committee members thanked staff for the work that went into preparing for the meeting. Chair Tran thanked Marsha Choo and Monica Macias for their reports.

ADJOURNMENT
Hearing no further business, Chair Tran adjourned the meeting at 3:55 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: December 13, 2023

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CalOptima Health Board Action Agenda Referral

Action To Be Taken February 1, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

6. Approve New CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services

Contacts

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

Recommended Actions

Approve new CalOptima Health medical policy GG.1357: Population Health Management Transitional Care Services.

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 that responds to individual member needs within the communities the plans serve. One component of the PHM Program is specific to transitional care services (TCS).

Discussion

CalOptima establishes new policies and procedures to implement federal and state laws, program regulations, contracts, and business practices. In November 2022, DHCS released All-Plan Letter (APL) 22-024: Population Health Management Policy and PHM Policy Guide, updated October 2023.

The purpose of the new GG.1357 policy is to describe the process by which CalOptima Health, delegated Health Networks, and providers engage and coordinate TCS for members in accordance with DHCS APL 22-024 and the PHM Policy Guide. The policy describes the comprehensive set of services that will support successful care transitions for members.

Fiscal Impact

The recommended action is operational in nature and has no anticipated fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2023-24 Operating Budget. To the extent there is any fiscal impact, staff will request additional resources in separate Board of Directors (Board) actions or in future operating budgets.

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 approve and adopt CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services.

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Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. APL 22-024 Population Health Management Policy Guide
2. DHCS CalAIM: Population Health Management (PHM) Policy Guide Updated: October 2023
3. New CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services

/s/ Michael Hunn *01/25/2024*

Authorized Signature **Date**

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State of California—Health and Human Services Agency
Department of Health Care Services

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: November 28, 2022

ALL PLAN LETTER 22-024
SUPERSEDES ALL PLAN LETTERS 17-012 AND 17-013

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: POPULATION HEALTH MANAGEMENT POLICY GUIDE

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to all Medi-Cal managed care health plans (MCPs) regarding the implementation of the Population Health Management (PHM) Program and the role of the PHM Policy Guide.

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 PHM Program.[1] The PHM Program seeks to establish a cohesive, statewide approach to all populations that brings together and expands upon many existing population health strategies. Under PHM, MCPs and their Networks and partners will be responsive to individual Member needs within the communities they serve while also working with a common framework and set of expectations.

PHM is a comprehensive, accountable plan of action for addressing Member needs and preferences, and building on their strengths and resiliencies across the continuum of care that:

- Builds trust and meaningfully engages with Members;
- Gathers, shares, and assesses timely and accurate data on Member preferences and needs to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes;
- Addresses upstream factors that link to public health and social services;
- Supports all Members staying healthy;
- Provides care management for Members at higher risk of poor outcomes;

[1] See Welfare and Institutions Code Section 14184.204. State law is searchable at: https://leginfo.legislature.ca.gov/. For more information on CalAIM, see: https://www.dhcs.ca.gov/calaim. For more information on the PHM Program, see: https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx.

- Provides transitional care services for Members transferring from one setting or level of care to another; and
- Identifies and mitigates social drivers of health to reduce disparities.

DHCS published a PHM Policy Guide in September of 2022 that incorporated stakeholder feedback.[2] The CalAIM PHM Policy Guide is a key DHCS guidance document that sets forth comprehensive requirements for all MCPs for the implementation of PHM, beginning on January 1, 2023.

POLICY:
Effective January 1, 2023, MCPs are required to establish a comprehensive PHM Program. The PHM Policy Guide is a resource for MCPs that builds upon the vision and foundational expectations outlined in the Final PHM Strategy and Roadmap.[3] DHCS' requirements for MCPs to implement the PHM Program are contained in the forthcoming 2024 MCP Contract [4] and PHM Policy Guide.

The PHM Policy Guide outlines policies and contains DHCS operational requirements and guidelines on the PHM Program. The PHM Policy Guide is available on the DHCS PHM webpage and is also posted as an attachment to this APL. DHCS may update the PHM Policy Guide to reflect the latest PHM Program requirements and guidelines. DHCS will notify MCPs in writing within 30 days of an update to the PHM Policy Guide.

Changes to the Health Risk Assessments (HRA) Process
Effective January 1, 2023, MCPs will no longer be required to follow the requirements outlined in APLs 17-012 and 17-013 related to HRAs. MCPs will be required to follow the policy related to changes to Seniors and Persons with Disabilities HRA requirements as outlined in the PHM Policy Guide.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required policies and procedures (P&Ps), the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) contract manager within 90 days of the release of this APL. If an MCP

[2] The PHM Policy Guide is available at: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf
[3] The Final PHM Strategy and Roadmap is available at: https://www.dhcs.ca.gov/CalAIM/Documents/Final-Population-Health-Management-Strategy-and-Roadmap.pdf.
[4] 2024 MCP Contract, Exhibit A, Attachment III, Population Health Management Requirements. MCP boilerplate contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD contract manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.[5] These requirements must be communicated by each MCP to all Subcontractors and Network Providers.
If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

[5] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

DEPARTMENT OF HEALTH CARE SERVICES

CalAIM: Population Health Management (PHM) Policy Guide

Updated: October 2023

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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I. Introduction

A. Purpose of the Population Health Management (PHM) Policy Guide

The California Advancing and Innovating Medi-Cal (CalAIM) PHM Policy Guide is one of three key California Department of Health Care Services (DHCS) guidance documents that set forth comprehensive requirements applicable for all Medi-Cal Managed Care health plans (MCPs) for the implementation of PHM, which began on January 1, 2023.

The other two guidance documents – All Plan Letter (APL) 22-024 "Population Health Management Policy Guide"[1] and the Amended 2023 MCP Contract provide baseline DHCS' requirements for MCPs to implement the PHM Program. The PHM Policy Guide, APL 22-024, and Amended 2023 MCP Contract build upon the vision and foundational expectations outlined in the Final PHM Strategy and Roadmap, which was released in July 2022.

The PHM Policy Guide outlines the expectations that DHCS has for how MCPs operate the PHM Program. Certain requirements will be phased in between January 1, 2023, and the effective date of the new MCP contract on January 1, 2024. The PHM Policy Guide will continue to evolve to clarify and provide details on the implementation of the PHM Program and will be regularly updated. Please refer to Section II-G for a detailed implementation timeline.

B. What Is the PHM Program?

The PHM Program is designed to ensure that all members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, which leads to longer, healthier, and happier lives, improved outcomes, and health equity. Specifically, the PHM Program intends to:

- Build trust with and meaningfully engage members;
- Gather, share, and assess timely and accurate data to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes;
- Address upstream drivers of health through integration with public health and social services;
- Support all members in staying healthy;
- Provide care management services for members at higher risk of poor outcomes;
- Provide transitional care services (TCS) for members transferring from one setting or level of care to another;
- Reduce health disparities; and
- Identify and mitigates Social Drivers of Health (SDOH)

[1]APL 22-024, which was published in November 2022, explains that the role of the PHM Policy Guide is to provide details of MCPs' existing contractual requirements for the PHM Program.

The launch of the PHM Program is part of a broader arc of change to improve health outcomes that is further articulated in DHCS' Comprehensive Quality Strategy (CQS), which emphasizes the long-lasting impact of coupling quality and health equity efforts with prevention.[2]

Under the PHM Program, MCPs and their networks and partners will be responsive to individual member needs within the communities they serve while working within a common framework and set of expectations.

While the PHM Program is a statewide endeavor that interacts with other delivery systems and carved-out services and requires meaningful engagement and partnerships with members and other stakeholders, the requirements outlined in the PHM Policy Guide apply specifically to MCPs.

C. What Is the PHM Service?

Supporting the PHM roll out, DHCS will be launching a statewide PHM Service. The PHM Service will provide a wide-range of Medi-Cal stakeholders with data access and availability for Medi-Cal members' health history, needs, and risks, including historical administrative, medical, behavioral, dental, social service data, and other program information from current disparate sources. The PHM Service will utilize this data to support risk stratification, segmentation, and tiering; assessment and screening processes; potential medical, behavioral, and social supports; and analytics and reporting functions. The PHM Service will also improve data accuracy and improve DHCS' ability to understand population health trends and the efficacy of various PHM interventions and strengthen oversight.

Given the period between the launch of the PHM Program (January 2023) and the launch of the PHM Service, DHCS is clarifying expectations for PHM Program implementation within two distinct time periods: before and after the PHM Service is available. Prior to the launch of the PHM Service and prior to any requirements to use the PHM Service, DHCS will not require MCPs to develop new capabilities and infrastructure that would subsequently be replaced by the PHM Service. Additional guidance on how MCPs will be expected to use the PHM Service is forthcoming.

D. PHM Program Requirements

On January 1, 2023, all MCPs will be required to meet PHM standards and have either full National Committee for Quality Assurance[3] (NCQA) Health Plan Accreditation or otherwise demonstrate to DHCS that they meet the PHM standards for NCQA Health

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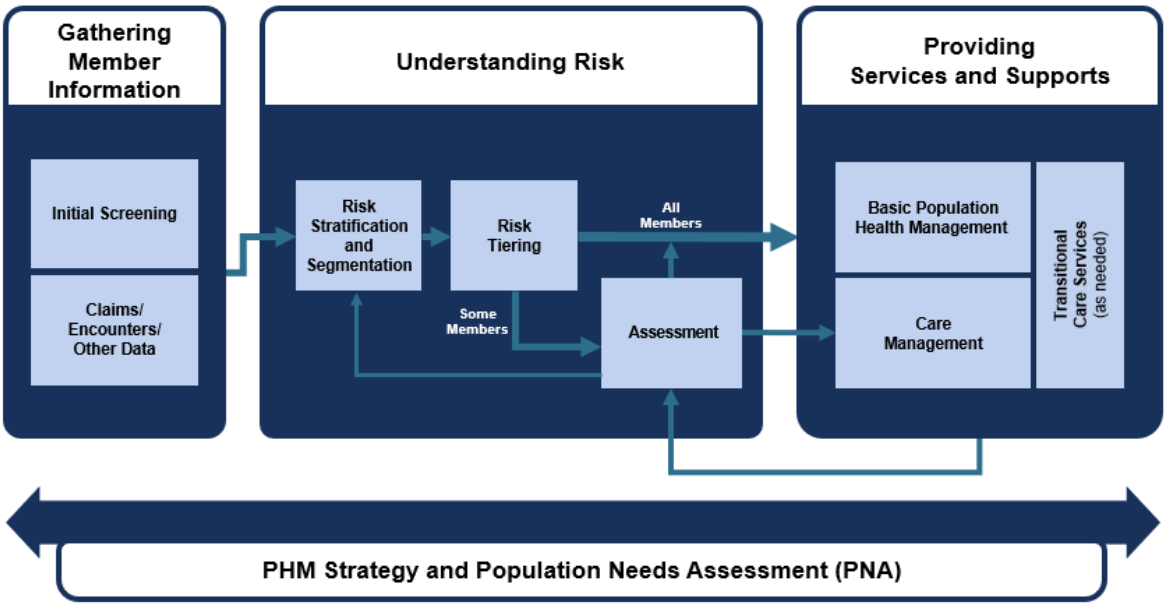
[2] The PHM Program is a part of CalAIM, which is a long-term commitment to transform and strengthen Medi-Cal, making the program more equitable, coordinated, and person-centered to help people maximize their health and life trajectory: https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-Infographic.pdf.

[3] NCQA is a nonprofit organization committed to evaluating and publicly reporting on the quality of MCPs.

Plan Accreditation.[4] By January 1, 2026, all MCPs must obtain NCQA Health Plan Accreditation and NCQA Health Equity Accreditation.

II. PHM Program

A. PHM Framework



DHCS uses the PHM Framework above consistently to promote common terminology and communication about PHM. MCPs are encouraged to use the PHM Framework within their organizations and are required to meet requirements in each of the four domains of this framework: PHM Strategy and Population Needs Assessment, Gathering Member Information, Understanding Risk, and Providing Services and Supports.

B. *(Updated August 2023)* Population Needs Assessment (PNA) and PHM Strategy

Note: This PHM Policy Guide has been updated as of August 2023 to provide near-term guidance on the modified PNA and PHM Strategy Deliverable. It will be further updated by the end of 2023 with more operational details, which will be informed by feedback received on DHCS' PNA Concept Paper (published May 2023) introducing DHCS' proposed approach for the modified PNA as well as by insights gained at various stakeholder forums and from additional policy and legal research.

The PNA is the mechanism that MCPs use to identify priority needs of their local communities and members and to identify health disparities. To support the success of the PHM Program and broader transformation efforts, DHCS is modifying MCPs'

[4] PHM standards are one component of NCQA Health Plan Accreditation, which also includes standards on Quality Management and Improvement, Network Management, Utilization Management, Credentialing and Recredentialing, Member' Rights and Responsibilities, Member Connections, and Medicaid Benefits and Services.

previous PNA requirements to include a central requirement that MCPs collaborate meaningfully with local health departments (LHDs) on their current or next cycle of community health assessments (CHAs)/Community Health Improvement Plans (CHIPs), with initiation efforts on the part of the MCPs beginning by January 1, 2024. MCPs may participate meaningfully by providing funding, staffing, and/or data. By the end of 2023, DHCS will update this policy guide to more comprehensively define "meaningful participation" by MCPs for 2024 and beyond.

DHCS' vision for the modified PNA is that closer collaboration with the public health system, and by extension of working within the CHA process with other community stakeholders, will deepen each MCP's understanding of its members and strengthen its relationship with the communities it serves. This collaboration will ultimately enhance MCPs' abilities to more holistically identify the needs and strengths within Member communities so that MCPs and their community partners can more effectively and sustainably improve the lives of Members and have fewer siloed approaches to population health management.

Related to the modified PNA, DHCS is creating a new annual PHM Strategy Deliverable, which requires MCPs to demonstrate meaningfully responding to community needs as well as to provide other updates on the PHM Program to inform DHCS' monitoring efforts.

All prime MCPs operating in a LHD's jurisdiction must ensure that any populations covered by a subcontracted plan are included in the PNA process. In California, most of the 61 LHDs operate at the county level, with three operating at the city level. Please see CDPH's list of all LHDs in California.

Requirements for 2023

In 2023, the following requirements apply:

- ***APL Requirements***. Effective January 1, 2023, MCPs are no longer required to submit an annual PNA and PNA Action Plan under the requirements of APL 19-011. DHCS has superseded APL-19-011 with APL 23-021, which provides guidance on the modified PNA and PHM Strategy Deliverable requirements. APL 23-021 states that further operational details and updates will be provided in this policy guide. MCPs remain accountable for meeting the cultural, linguistic, and health education needs of members, as defined in state and federal regulations.[5] DHCS' broader monitoring approach will consider, at minimum, findings from the

[5] MCPs' contractual requirements related to the PNA, the PHM Strategy, and other PHM deliverables remain consistent with Title 22 of the California Code of Regulations (CCR), sections 53876, 53851(b)(2), 53851(e), 53853(d), and 53910.5(a)(2); Title 28 of the CCR, section 1300.67.04; and Title 42 of the Code of Federal Regulations (CFR), sections 438.206(c)(2), 438.330(b)(4), and 438.242(b)(2).

redesigned PNA process (e.g., learnings from MCPs' participation in the LHDs' CHA/CHIP processes), NCQA deliverables, and feedback from other community partners with whom DHCS expects the MCPs to collaborate.

- ***2023 PNA and PHM Strategy Deliverable Submission Requirements***. In October 2023, all prime MCPs will be required to submit the inaugural PHM Strategy Deliverable using the DHCS template that addresses the NCQA and LHD collaboration requirements described below. Plans exiting a jurisdiction by January 1, 2024, do not need to complete deliverable activities nor submit this template; however, plans entering a jurisdiction by January 1, 2024, must complete deliverable activities and submit this template. Each template attestation and/or narrative should be inclusive of any subcontracted populations (subcontractor entities do not have to fill out this template separately/independently of prime MCPs). The 2023 PHM Strategy Deliverable replaces the previously required PNA Action Plan and serves as a precursor to future annual PHM Strategy Deliverable submissions (2024 and beyond).

    - ***NCQA Health Plan PHM Requirements***. As described earlier in this policy guide, all MCPs must meet NCQA Health Plan PHM requirements (effective January 1, 2023).[6] By January 1, 2026, all MCPs must obtain NCQA Health Plan Accreditation and NCQA Health Equity Accreditation. Deliverables due to NCQA are separate from the deliverables that must be submitted to DHCS.
        - *NCQA Accredited Plans:* In October 2023, MCPs must, for the first time, demonstrate that they have met NCQA population health requirements by submitting their PHM Strategy, which includes a Population Assessment of a health plan's members, to DHCS as part of the 2023 PHM Strategy Deliverable.
        - *Non-NCQA Accredited Plans:* These MCPs are still responsible for demonstrating to DHCS that they meet the PHM standards for NCQA Health Plan Accreditation. Recognizing they will need time to prepare NCQA deliverables, these plans must submit their PHM Strategy (inclusive of Population Assessment) to DHCS by December 31, 2023.

- ***LHD Collaboration Requirements***. All MCPs must describe how they will meet collaboration requirements with the LHDs in their service area(s) at least once before the PHM Strategy Deliverable is due in October (or December for non-accredited MCPs). The meeting(s) serve to help prepare MCPs for the more robust collaboration with LHDs that will be required starting January 1, 2024. The objectives of the meeting(s) should, at minimum, include a) early planning around how MCPs may meaningfully participate in the LHDs' current or next cycle of

[6] All MCPs are responsible for obtaining NCQA accreditation standards from NCQA. DHCS will not provide these standards to MCPs.

CHAs/CHIPs, and b) co-development of at least one shared and meaningful goal that is accompanied by an objective that is SMART (specific, measurable, achievable, realistic, and time-bound). The objective should be aligned with DHCS' Bold Goals (as described in DHCS' Comprehensive Quality Strategy) and support a relevant LHD project that is currently being implemented or about to be launched. The objective should have a start date prior to January 2024 and be achievable in 1-2 years.

Requirements for 2024 and Beyond

Starting in 2024, each MCP will meet the PNA requirement by demonstrating meaningful participation in the LHDs' CHA/CHIP processes in the service area(s) where the MCP operates. MCPs must still follow all applicable NCQA requirements and subsequently submit an annual PHM Strategy Deliverable to DHCS. By the end of 2023, DHCS will be updating this policy guide with further operational details on the PNA and PHM Strategy Deliverables due in 2024 and beyond.

C. Gathering Member Information

An effective PHM approach begins with gathering accurate and robust information to understand each member's health and social needs, as well as their health goals and preferences, to ensure that they receive the right services at the right time and right place.

1) Leveraging Existing Health and Social Data

Building upon current requirements related to MCPs' use of various data sources for internal management and reporting purposes,[7] MCPs will be required to leverage a broad set of data sources to support PHM Program information gathering, inform Risk Stratification and Segmentation (RSS), provide a broader understanding of the health needs and preferences of the member, and support more meaningful member engagement.

Data to be used as part of information gathering and to inform RSS include:

- Screenings and assessments;
- Managed care and fee-for-service (FFS) medical and dental claims and encounters;
- Social services reports (e.g., CalFresh; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); California Work Opportunity and Responsibility to Kids (CalWORKs); In-Home Services and Supports (IHSS));
- Electronic health records;
- Referrals and authorizations;

[7] Under current requirements related to Management Information System (MIS) capabilities, MCPs must utilize various data elements both for internal management use and to meet the data quality and timeliness requirements of DHCS' Encounter Data submission.

- MCP behavioral health Screenings, Brief Interventions, and Referral to Treatment (SBIRT), medications for addiction treatment (MTOUD, also known as Medications for Opioid Use Disorder), and other substance use disorders (SUD), and other non-specialty mental health services information;[8]
- County behavioral health Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), and Specialty Mental Health System (SMHS) information available through the Short-Doyle/Medi-Cal and California Medicaid Management Information Systems (CA-MMIS) claims system;[9]
- Pharmacy claims and encounters;
- Disengaged member reports (e.g., assigned members who have not utilized any services);
- Laboratory test results;
- Admissions, discharge, and transfer (ADT) data;
- Race, ethnicity, and language information;
- Sexual orientation and gender identity (SOGI) information;
- Disability status;
- Justice-involved data;
- Housing reports (e.g., through the Homeless Data Integration System (HDIS), Homelessness Management Information System (HMIS), and/or Z-code claims or encounter data); and
- For members under 21, information on developmental and adverse childhood experiences (ACEs) screenings.

DHCS understands that MCPs may have limited access to some of the required RSS data listed above and that some of these data may not be available until the PHM Service is fully operationalized. As such, during this period prior to Service launch, MCPs will be expected to make a good-faith effort to use and integrate the above data to the greatest extent possible from currently available data sources.

Once the PHM Service is available and supports access to and use of required data sources, MCPs will be required to use the PHM Service and the available data accessible through the Service – in accordance with federal and state privacy rules and regulations – to conduct RSS, screening and assessment, basic PHM, and member engagement and health education activities. DHCS anticipates only having historical data (e.g., through claims/encounters) at the time of PHM Service launch and expects MCPs to source more real-time data (e.g., ADT feeds) from local data sources even after the PHM Service is available.

Lastly, MCPs must expand their MIS capabilities to integrate these additional data sources in accordance with the MIS Capability section of the Amended 2023 MCP

[8] In certain circumstances, the sharing of 42 C.F.R. Part 2 data may require a member's signed consent in accordance with state and federal law; please refer to the 2022 DHCS Data Sharing Authorization Guidance for more information.
[9] In certain circumstances, the sharing of 42 C.F.R. Part 2 data may require a member's signed consent in accordance with state and federal law; please refer to the 2022 DHCS Data Sharing Authorization Guidance for more information.

Contract and all NCQA PHM standards. MCPs must adhere to data-sharing requirements as defined by the California Health & Human Services Agency Data Exchange Framework.

2) *(Updated October 2023)* Streamlining the Initial Screening Process

DHCS is issuing the guidance below to streamline several initial screening processes while ensuring compliance with federal and NCQA requirements. Change is needed with respect to screening and assessment as existing mechanisms do not always cultivate member trust and are often burdensome to members and other stakeholders.

Effective on January 1, 2023, DHCS is implementing the following changes to the Health Information Form (HIF)/Member Evaluation Tool (MET) and the Individual Health Education Behavior Assessment (IHEBA)/Staying Healthy Assessment (SHA).

Modifications to the HIF/MET, Initial Health Appointment (IHA), and the IHEBA/SHA

- The **HIF/MET** will still be required to be completed within 90 days of enrollment for new members. However, DHCS is clarifying that:
    - MCPs may contract with providers for HIF/MET. If contracted, the provider is responsible for following up on positive screening results. If the HIF/MET is not contracted to be done by providers, the MCP must either directly follow up on positive screening results or contract with the provider to complete the follow-up (and share relevant information with the provider to do so).
    - IHA[10] results that are completed and shared back with the MCP within 90 days of enrollment would fulfill the HIF/MET requirement and, thus, the federal initial screening requirement.
- **The IHEBA/SHAs are eliminated.** However, DHCS is preserving the following requirements:
    - The **IHA(s)** must be completed within 120 days[11] of enrollment for new members and must continue to include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases.[12] An IHA is not necessary if the member's PCP determines that the member's medical record contains complete information that was updated within the previous 12 months. This information must be assessed by the PCP during the first 120 days of member enrollment. The conclusion of the PCP's assessment must be documented in the member's medical record. Other reasons a member may not complete an IHA are the following: Member disenrolled before 120 days; Member refuses

[10] Starting in 2023, the Initial Health Assessment is known as the "Initial Health Appointment(s)." Current requirements for the Initial Health Assessment are contained in APL 18-004, APL 20-004 (rev.), APL 22-017, and APL 22-030.
[11] For members less than 18 months of age: within 120 calendar days of enrollment or within periodicity timelines established by the AAP Bright Futures for age 2 and younger, whichever is sooner. For adults aged 21 and over: within 120 days of enrollment. Specific time frames are included in the 2022 Medi-Cal Managed Care Contracts.
[12] These required IHA elements are specified in 22 C.C.R. § 53851(b)(1).

IHA completion; and reasonable attempts by the MCP or delegated provider to contact the member were unsuccessful. All IHA attempts should be documented in the member's medical record.

- For children and youth (i.e., individuals under age 21), Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings will continue to be covered in accordance with the American Academy of Pediatrics (AAP) /Bright Futures periodicity schedule, as referenced in APL 23-005.[13]
- MCPs should continue to hold network providers accountable for providing all preventive screenings for adults and children as recommended by the United States Preventive Services Taskforce (USPSTF) but will no longer require all of these elements to be completed during the initial appointment, so long as members receive all required screenings in a timely manner consistent with USPSTF guidelines.
- DHCS will leverage existing Managed Care Accountability Sets (MCAS) measures focused on preventive services, such as Child and Adolescent Well-Care Visits and Adults' Access to Preventive/Ambulatory Health Services, as proxies for monitoring the IHAs. A sample list of MCAS measures that will be used as a proxies is outlined below.

Sample MY 2023/RY 2024 MCAS Quality Measures As Proxies for the IHA(s)
• Depression Screening and Follow-Up for Adolescents and Adults • Child and Adolescent Well – Care Visits • Childhood Immunization Status – Combination 10 • Developmental Screening in the First Three Years of Life • Immunizations for Adolescents – Combination 2 • Lead Screening in Children • Topical Fluoride for Children • Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits • Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits • Chlamydia Screening in Women • Breast Cancer Screening • Cervical Cancer Screening • Adults' Access to Preventive/Ambulatory Health Services

[13] For more information about the AAP/Bright Futures initiative and to view the most recent periodicity schedule and guidelines, go to https://brightfutures.aap.org/Pages/default.aspx. Additional information on the periodicity schedule is available at https://www.aap.org/en-us/professional-resources/practicetransformation/managing-patients/Pages/Periodicity-Schedule.aspx.

Corresponding APL Updates

APLs	Upcoming Updates and Timing
APL 16-014 "Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries"	• This APL will be superseded to decouple requirements from outdated IHEBA/SHA requirements sometime in the future
APL 18-004 "Immunization Requirements"	• Supersedes APL 07-015 and PL 96-013.
APL 20-004 "Emergency Guidance for Medi-Cal Managed Care Plans in Response to COVID-19"	• Revised April 2023.
APL 22-030 "Initial Health Appointment"	• Supersedes APL 13-017 and PLs 13-001 and 08-003.

In addition to the above, DHCS is considering other ways to streamline the initial screening process by leveraging the PHM Service, when available, which will help reduce member screening fatigue as well as better connect members to services and supports and improve data sharing between plans and providers via California's Data Exchange Framework. Through design work on the PHM Service, DHCS is exploring how the PHM Service can host screening and assessment functionalities that pre-populate relevant previously collected data to further mitigate duplication and burden on members.

3) *(Updated October 2023)* Guidance for Screening and Assessments for Transitioning Members During the 2024 MCP Transition

Beginning in 2024, MCPs will be subject to new requirements to rigorously advance health equity, quality, access, accountability and transparency to improve the Medi-Cal health care delivery system. As part of this transformation, some MCPs are changing on January 1, 2024 as a result of how DHCS contracts with MCPs. Collectively, these changes comprise the January 1, 2024, MCP Transition.[14]

This section explains requirements for three assessment and screening tools—the HIF/MET, IHA, and HRA-- in the context of the 2024 MCP Transition. This section refers to an MCP receiving new members from a previous MCP during the 2024 MCP Transition as a "receiving MCP" and those members who are in transition from one MCP to another as "transitioning members."

[14] For more details, see the 2024 Transition Policy Guide.

HIF/ MET

Receiving MCPs must complete the HIF/MET for transitioning members within 90 days of January 1, 2024 regardless of whether the previous MCP completed a HIF/MET for the member. MCPs may fulfill the HIF/MET requirement in ways consistent with this PHM Policy Guide.

IHA

Receiving MCPs must ensure that a member has an IHA within 120 days of the member transitioning to the receiving MCP. The receiving MCP is not required to complete an IHA within 120 days if the member's primary care physician (PCP) determines that the member's medical record contains complete information, updated within the previous 12 months. Even if the member's PCP determines that the member's record contains complete information such that an IHA does not need to be conducted within 120 days, the receiving MCP still needs to complete a HIF/MET for members within 90 days of a member transitioning. All other IHA requirements apply.

HRA

Receiving MCPs must adhere to the following for transitioning members identified as Seniors and Persons with Disabilities (SPD):

- **Transitioning members with no record of an HRA**: The receiving MCP must complete an HRA for transitioning members identified as SPD who do not have a record of an HRA and meet the definition of "high risk" per guidance outlined in the CalAIM: PHM Policy Guide and APL 22-024.[15]
- **Transitioning members who have an existing HRA**:
    - For transitioning members authorized to receive Long-Term Services and Supports (LTSS), the receiving MCP may rely upon an HRA conducted by the previous MCP on or after January 1, 2023. The receiving MCP must conduct an HRA if the previous MCP conducted the HRA before January 1, 2023, or if the transitioning member experienced a significant change in health status or level of care since the previous HRA, or upon receipt of new information that the receiving MCP determines as potentially changing a member's level of risk and need.
    - For all other transitioning members, the receiving MCP may rely upon an HRA conducted by the previous MCP before, on, or after January 1, 2023. The receiving MCP must conduct an HRA if the transitioning member experienced a significant change in health status or level of care since the previous HRA, or upon receipt of new information that the receiving MCP determines as potentially changing a member's level of risk and need.

[15] CalAIM: PHM Policy Guide, Section D. Understanding Risk. Assessment and Reassessment to Understand Member Needs; APL-22-024

D. Understanding Risk

1) RSS and Risk Tiers

Risk Stratification and Segmentation (RSS) means the process of differentiating all members into separate risk groups and/or meaningful subsets. RSS results in the categorization of all members according to their care and risk needs at all levels and intensities.

Risk tiering means the assigning of members to risk tiers that are standardized at the State level (i.e., high, medium-rising, or low risk), with the goal of determining the appropriate level of care management or other specific services for members at each risk tier.

In accordance with the Population RSS and Risk Tiering section of the Amended 2023 MCP Contract, DHCS is setting expectations toward greater standardization with regard to how MCPs use RSS algorithms, employ risk tiers, and connect members to services.

The PHM Service will include a single, statewide, open-source RSS methodology with standardized risk tier criteria that will place all Medi-Cal members into high-, medium-rising-, and low-risk tiers. Therefore, DHCS requirements for RSS and risk tiering across all populations are set for two distinct time periods: prior to and after the RSS and risk tiering functionalities become available.

For the Period Prior to Availability of the PHM Service RSS and Risk Tiering Functionalities

a. RSS:

MCPs must meet the following requirements prior to the PHM Service's RSS functionalities becoming available:

- Utilize an RSS approach that:
    - Complies with NCQA PHM standards, including using utilization data integrated with other data sources such as findings from the PNA, clinical and behavioral data, or population and social needs data;
    - Incorporates a minimum list of data sources listed in the "Information Gathering" section to the greatest extent possible;
    - Avoids and reduces biases to prevent exacerbation of health disparities;
        - Many current RSS methodologies rely on utilization or cost data only, which may result in racial, condition, or age bias. Many RSS methodologies look only at past costs or utilization, which tends to result in prioritizing white patients over Black patients because white patients have higher medical expenses. Similarly, conditions that generate greater health care expenditures, such as those requiring dialysis, are prioritized over those that generate fewer expenditures. Lastly, older individuals with more chronic, complex conditions tend to be prioritized over younger individuals.[16]

[16] "Beyond Racial Bias: Rethinking Risk Stratification In Health Care," Health Affairs Blog, January 15, 2020. DOI: 10.1377/hblog20200109.382726.

        - To address these biases and improve outcomes for all of MCPs' members, MCPs are encouraged to use all relevant data, keep the information updated (e.g., through care managers), continuously evaluate key performance indicators and RSS outputs, use appropriate metrics to measure the accuracy and effectiveness of RSS model prediction of people who do or do not need help, and monitor whether RSS improves care for all populations.[17,18]
    - Stratifies members at least annually and during each of the following time frames:
        - Upon each member's enrollment.
        - Annually after each member's enrollment.
        - Upon a significant change in the health status or level of care of the member (e.g., inpatient medical admission or emergency room visit, pregnancy, or diagnosis of depression).
        - Upon the receipt of new information that the MCP determines as potentially changing a member's level of risk and need, including but not limited to information contained in assessments or referrals for Complex Care Management (CCM), Enhanced Care Management (ECM), TCS, and Community Supports.
- Continuously reassess the effectiveness of the RSS methodologies and tools.

b. Risk Tiering:

Prior to the PHM Service's RSS and risk tiering capabilities becoming available, MCPs are **not** required to use standardized risk tiers (i.e., high, medium-rising, or low) across their members but must use their RSS approach to identify members who should be connected to available interventions and services, including care management, and ensure all members are connected to appropriate Basic Population Health Management (BPHM).

After the PHM Service RSS and Risk Tiering Functionalities Are Available

a. RSS and Risk Tiers

DHCS recognizes that some plans have developed and significantly invested in their own RSS approaches. Once the PHM Service's RSS functionality is available and vetted, DHCS will require MCP plans to use the PHM Service RSS outputs and tiers to support statewide standardization and comparisons; MCPs may supplement these outputs with local data sources and methodologies.

Once the PHM Service RSS and risk tiering functionalities become available, the PHM Service will use the standardized criteria for all individuals served by Medi-Cal, taking information from all delivery systems into account. The PHM Service will place each individual into a risk tier (i.e., high, medium-rising, or low). MCPs will be required to use

[17] "Beyond Racial Bias: Rethinking Risk Stratification In Health Care," Health Affairs Blog, January 15, 2020. DOI: 10.1377/hblog20200109.382726.
[18] "Topic-Specific Implementation Guides." Comprehensive Primary Care. The Center for Medicare & Medicaid Innovation. June 2014. https://downloads.cms.gov/files/cmmi/cpci-combined-implementationguide.pdf.

the PHM Service risk tiers to identify and assess member-level risks and needs and, as needed, connect members to services.

The risk tiers identified through the PHM Service will set a standard to identify members who require further assessment and connection to appropriate services. DHCS acknowledges that since the PHM Service will be using historical data, MCPs may have local data sources or real-time data that could supplement these outputs and may be used for the purpose of identifying additional members for further assessments and services. For example, while an MCP must assess the needs of any member who is identified as high-risk through the PHM Service, MCPs may use additional data sources to identify other members who require an assessment that the PHM Service may not have identified.

MCPs will not be able to manually "override" a risk tier given by the PHM Service on a member, as these risk tiers will be used to ensure equity and accountability across the state; however, MCPs will be expected to work with network providers to exercise judgment and shared decision-making with the member about the services a member needs, including through use of real-time information that may be available and through the assessment/reassessment process described below. The PHM Service risk tiers are designed to be a starting point for assessment but not a requirement for or barrier to services.

DHCS will issue additional guidance on MCPs' use of risk tiers and required reporting prior to the statewide launch of the PHM Service.

2) Assessment and Reassessment to Understand Member Needs

After the RSS and risk tiering processes identify members that may need available interventions and services, additional efforts are required to better understand the members' needs and preferences and meaningfully engage them in the most appropriate services and supports. In the context of the PHM Framework, the term "assessment" describes this process, and it involves requesting information from members about their health and individual needs. Generally, MCPs are expected to contract with providers to conduct assessment and integrate it with care and care management processes to the greatest extent possible, rather than siloed at the plan level. Either an MCP or a contracted provider, such as a Primary Care Provider (PCP), will conduct an additional assessment of members by asking them questions in a culturally and linguistically appropriate manner that builds trust with the member and seeks to define the nature of the risk factor(s) and/or problem(s) a member is experiencing; determine a member's overall needs and preferences, health goals, and priorities; and aid in the development of specific treatment recommendations to meet the member's needs and preferences.

Importantly, this assessment process is separate and distinct from "screening" in that it is more comprehensive, and because it occurs after members have been identified by the RSS and risk tiering processes (which is informed by screening data).

Populations Required to Receive an Assessment and Re-assessment

Assessments vary in length and scope, and some are mandated by federal and/or state law, by NCQA, or by DHCS' new PHM requirements. Populations required to receive an assessment include:

- Those with long-term services and supports (LTSS) needs (as required by federal and state law and waiver).[19]
- Those entering CCM (per NCQA).
- Those entering ECM.
- Children with Special Health Care Needs (CSHCN).[20]
- Pregnant individuals.[21]
- Seniors and persons with disabilities who meet the definition of "high risk" as established in existing APL requirements,[22] namely:
    - Members who have been authorized to receive:
        - IHSS greater than, or equal to, 195 hours per month;
        - Community-Based Adult Services (CBAS), and/or
        - Multipurpose Senior Services Program (MSSP) Services.
    - Members who:
        - Have been on oxygen within the past 90 days;
        - Are residing in an acute hospital setting;
        - Have been hospitalized within the last 90 days or have had three or more hospitalizations within the past year;
        - Have had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g., multiple prescriptions consistent with the diagnosis of chronic diseases);
        - Have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern (e.g., homelessness);
        - Have end-stage renal disease, acquired immunodeficiency syndrome (AIDS), and/or a recent organ transplant;
        - Have cancer and are currently being treated;

[19] 42 C.F.R. § 438.208; CA W.I.C. § 14182(c)(12). A Standard Terms and Conditions of Federal 1115 Demonstration Waiver titled "A Bridge to Reform."

[20] Aligned with federal regulations, DHCS CQS states, "Each MCP is required to implement and maintain a program for [CSHCN], who are defined by the state as having, or being at an increased risk for, a chronic physical, behavioral, developmental, or emotional condition, and who require health or related services of a type or amount beyond that generally required by children. Each MCP's CSHCN program is required to include standardized procedures for identifying CSHCN at enrollment and on a periodic basis after enrollment. Members identified as CSHCN must receive comprehensive assessment of health and related needs. The MCP must implement methods for monitoring and improving the quality and appropriateness of care for CSHCN."

[21] Medi-Cal Managed Care Boilerplate Contract, Exhibit A, Attachment 10, Scope of Services, 7. Pregnant Women.

[22] APL 22-024.

        - Are pregnant;
        - Have been prescribed antipsychotic medication within the past 90 days;
        - Have been prescribed 15 or more prescriptions in the past 90 days;
        - Have a self-report of a deteriorating condition; and
        - Have other conditions as determined by the MCP, based on local resources.
- Prior to the statewide RSS and risk tiers becoming available through the PHM Service, MCPs will be required to assess members who are identified at high risk through their own RSS approaches (e.g., upon enrollment, annually after enrollment, based on significant change in health status or level of care, or upon receipt of new information that the MCP determines as potentially changing a member's level of risk and need).
- Once the statewide RSS and risk tiers are available through the PHM Service, MCPs will be required at a minimum to assess members who are identified as high-risk through the PHM Service.

An annual re-assessment is required for CSHCN[23] and those with LTSS needs[24]. Prenatal, postpartum and trimester reassessments that are comparable to the American College of Obstetricians and Gynecologists (ACOG) and Comprehensive Perinatal Services Program (CPSP) standards per Title 22 C.C.R are required for pregnant individuals. There is no annual re-assessment requirement for those enrolled in ECM or CCM, and Seniors and Persons with Disabilities. However, most MCPs complete an annual re-assessment for members enrolled in ECM or CCM.

Changes to Assessment Requirements

To reduce current duplicative and burdensome processes, MCPs are encouraged to contract with providers to conduct assessment and integrate it with care and care management to the greatest extent possible. Whether the assessment is performed in person, telephonically, or by telehealth, it should be conducted in a manner that promotes full sharing of information in an engaging environment of trust and in a culturally and linguistically appropriate manner.

Assessment results are also expected to be shared between MCPs and providers responsible for following up with the member, similar to the expectation to be put in place for HIF/MET screening (above). MCPs must also follow up on any positive assessment result or contract with the PCP to complete the follow-up.

[23] Centers for Medicare and Medicaid Services: Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability Final Rule
[24] 42 CFR § 438.208 - Coordination and continuity of care.

Box A: Changes to Seniors and Persons with Disabilities Health Risk Assessment (HRA) Requirements

Effective January 1, 2023, assessment requirements for Seniors and Persons with Disabilities (which are called HRA requirements) are simplified, while specific member protections are kept in place. DHCS has consistently heard feedback that the existing HRA requirements often contribute to duplicative or otherwise burdensome processes for members, whereby the same information is taken in via one or more screening tools and by the HRA, as well as through the usual course of care at the provider level. Therefore:

Starting in 2023, MCPs are not required to retain the use of their existing HRA tools that were previously approved by DHCS under the APLs 17-012 and 17-013, although they may choose to do so, and instead must follow stipulations put forth in APL 22-024. Furthermore, MCPs, or contract entities, must continue to assess members who may need LTSS, using the existing standardized LTSS referral questions (see Appendix 3) according to federal and state law. MCPs must also comply with federal regulations that stipulate specific care plan requirements for members with LTSS needs.

Additionally, for 2023, DHCS retains the requirement that MCPs assess Seniors and Persons with Disabilities who meet the definition of "high risk" for Seniors and Persons with Disabilities as outlined above, even if they do not have LTSS needs. MCPs may alternatively leverage their ECM and/or CCM assessment tools, or components of those tools, for Seniors and Persons with Disabilities considered at "high risk." If MCPs decide to retain existing HRA tools, they are encouraged to adapt them to allow delegation to providers.

DHCS also simplified the expected timeline for assessment of those with LTSS needs to align with NCQA's requirements for care management assessments, which include beginning to assess within 30 days of identifying the member through RSS, referral, or other means, and completing assessment within 60 days of that identification.

Corresponding APL Updates

APLs	Upcoming Updates and Timing
APL 22-024 "Population Health Management Policy Guide"	• Supersedes APL 17-013 and APL 17-012.

E. Providing PHM Program Services and Supports

1) Basic Population Health Management (BPHM)

BPHM is an approach to care that ensures 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. In contrast to care management, which is focused on populations with significant or emerging needs, all MCP members receive BPHM, regardless of their level of need. BPHM replaces DHCS' previous "Basic Case Management" requirements.

BPHM includes access to primary care, care coordination,[25] navigation and referrals across health and social services, information sharing, services provided by Community Health Workers (CHWs) under the new CHW benefit, wellness and prevention programs, chronic disease programs, programs focused on improving maternal health outcomes, and case management services for children under EPSDT.

Although the key components of BPHM are not new, DHCS has not previously articulated them as a comprehensive package of services and supports that all MCP members can expect.

BPHM is ultimately the responsibility of the MCP. Some functions of BPHM will need to be retained by the MCP, such as authorizing specialty services in a timely manner and providing a full suite of wellness and prevention and chronic disease management programs. However, MCPs are encouraged to contract with providers to provide certain components of BPHM, as described below, while ensuring appropriate oversight in meeting required responsibilities and functions. For example:

- For members who are successfully engaged in primary care, for example, MCPs should contract with PCPs (including Federally Qualified Health Centers (FQHCs), counties, or other primary care) to be responsible for select care coordination and health education functions, whenever feasible.
- For members who have been assigned a PCP but have not yet engaged with the PCP (e.g., assigned but not seen or lost to follow-up), MCPs may contract with the PCP to provide outreach. If the PCP makes contact with and engages the member, the MCP may also contract with the PCP for BPHM care coordination and health education functions whenever feasible. If a member does not engage with a PCP, MCPs are fully responsible for the provision of BPHM.
- For members enrolled in ECM, and since ECM, by design, happens in the community by an ECM provider, the assigned ECM Lead Care Manager is responsible for ensuring that BPHM is in place as part of their care management.

Required BPHM Elements and Processes:

In accordance with the Basic Population Health Management section of the Amended 2023 MCP Contract, MCPs must comply with the following requirements:

a. Access, Utilization, and Engagement with Primary Care

To ensure all members have access to and are utilizing primary care, MCPs must:

[25] 42 CFR § 438.208

- Ensure members have an ongoing source of primary care;
- Ensure members are engaged with their assigned PCPs (such as helping to make appointments, arranging transportation, and providing health education on the importance of primary care);
- Identify members who are not using primary care via utilization reports and enrollment data, which are stratified by race and ethnicity;
- Develop strategies to address different utilization patterns; and
- Ensure non-duplication of services.

All BPHM services should promote health equity and align with National Standards for Culturally and Linguistically Appropriate Services (CLAS), which is a U.S. Department of Health and Human Services (HHS)-developed framework of 15 standards focused on the delivery of services in a culturally and linguistically appropriate manner that is responsive to patient needs, beliefs, and preferences.

Starting in 2024, DHCS will expand reporting requirements to include reporting on primary care spending as a percentage of total spending stratified by age ranges and race/ethnicity.

b. Care Coordination, Navigation, and Referrals Across All Health and Social Services, Including Community Supports

Even though some Medi-Cal services are typically carved-out of the MCP benefit package, MCPs must ensure that members have access to needed services that address all their health and health-related needs, including developmental, physical, mental health, SUD, dementia, LTSS, palliative care, oral health, vision, and pharmacy needs.

MCPs are required to partner with primary care and other delivery systems to guarantee that members' needs are addressed. This includes ensuring that each member's assigned PCP plays a key role in coordination of care, ensuring each member has sufficient care coordination and continuity of care with out-of-network providers, and communicating with all relevant parties on the care coordination provided. MCPs must also assist members in navigation, provider referrals, and coordination of health and services across MCPs, settings, and delivery systems.

MCPs should begin to establish relationships and processes to meet Closed Loop Referral requirements by January 2025. Closed Loop Referrals are defined in the 2024 Re-Procurement as coordinating and referring the member to available community resources and following up to ensure services were rendered. MCPs must ensure Closed Loop Referrals, in compliance with all federal and state laws, to:

- ECM;
- Community Supports;
- Services provided by CHWs, peer counselors, and local community organizations;
- Dental providers;
- California Children's Services (CCS);
- Developmental Services (DD);

- CalFresh;
- WIC providers;
- County social service agencies and waiver agencies for IHSS and other home- and community-based services (HCBS); and
- The appropriate delivery system for specialty mental health services to ensure members receive timely mental health services (in the MCP provider network, county Mental Health Plan (MHP) network, or Medi-Cal FFS delivery system) without delay regardless of where they initially seek care, in accordance with DHCS' "No Wrong Door" policy;[26] and
- The appropriate delivery system for SUD services (in DMC or DMC-ODS).[27]

Beginning in January 2025, MCPs are also required to coordinate warm handoffs with local health departments and other public benefits programs including, but not limited to, CalWORKs, Early Start, and Supplemental Security Income (SSI).

Starting in January 2024, MCPs are required to enter into Memorandums of Understanding (MOUs) with various programs and services, including county MHPs to facilitate care coordination and information exchange.[28,29]

c. Information Sharing and Referral Support Infrastructure

To support effective BPHM, MCPs are required to implement information-sharing processes and referral support infrastructure. MCPs must ensure appropriate sharing and exchange of member information and medical records by providers and MCPs in accordance with professional standards and state and federal privacy laws and regulations.

d. *(Updated August 2023)* Integration of Community Health Workers (CHWs) in PHM

MCPs will be required to describe how they will integrate CHWs in their PHM Strategy and had to attest this integration as part of their PHM Readiness Deliverable. As trusted members of the community, CHWs may be able to address a variety of health and health-related issues, including, but not limited to: supporting members' engagement with their PCP, identifying and connecting members to services that address SDOH needs, promoting wellness and prevention, helping members manage their chronic disease, and supporting efforts to improve maternal and child health. CHWs may include individuals known by a variety of job titles, including promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified below

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[26] APL 22-005

[27] 2024 Re-Procurement, Exhibit A, Attachment III, 5.5. This requirement will take effect in 2024.

[28] Amended 2023 MCP Contract.

[29] DHCS has launched the CalAIM Behavioral Health Quality Improvement Program (BH QIP). BHQIP has three domains, one of which focuses on data-sharing agreements among MCPs, county MHPs, and DMC-ODS plans. More information is available at https://www.dhcs.ca.gov/bhqip.

DHCS launched a new CHW benefit on July 1, 2022, which is a pathway for reimbursement for a specific set of CHW services. These reimbursable CHW services are defined by State Plan Amendment 22-0001 and Title 42 Code of Federal Regulations (C.F.R.) Section 440.130(c).[30,31] Even prior to the launch of this new benefit, MCPs may have already employed CHWs to implement a wide array of activities, including BPHM-related interventions, such as wellness and prevention. The new CHW benefit provides a new mechanism for providing and reimbursing for BPHM services provided by CHWs.

e. *(Updated August 2023)* Wellness and Prevention Programs

MCPs are required to provide comprehensive wellness and prevention programs that, at minimum, meet NCQA requirements, including offering evidence-based self-management tools that provide information on at least the following areas:

- Healthy weight (BMI) maintenance
- Smoking and tobacco use cessation
- Encouraging physical activity
- Healthy eating
- Managing stress
- Avoiding at-risk drinking
- Identifying depressive symptoms

Through their required annual PHM Strategy, MCPs will report how they are using community-specific information, gained in the more collaborative PNA efforts starting in 2024, to design and implement evidence-based wellness and prevention strategies to meet the unique needs of their populations that are inclusive of addressing one or more of the Bold Goals Initiatives described in DHCS' CQS. Starting in 2024, MCPs will be required to report annually, through their PHM Strategy, on how they are using community-specific information, gained in the more collaborative PNA efforts to design and implement evidence-based wellness and prevention strategies to meet the unique needs of their populations, as well as to drive toward the Bold Goals Initiative in DHCS' CQS. The expectation is that over time, these wellness programs result in improved outcomes, such as decreasing population prevalence of specific chronic diseases, rates of strokes and heart attacks, food access insecurity, and other conditions amenable to upstream risk factor modification.

f. Programs Addressing Chronic Disease

MCPs are required to offer evidence-based disease management programs in line with NCQA requirements at a minimum. These programs must incorporate health education interventions, identify members for engagement, and seek to close care gaps for the cohorts of members participating in the interventions with a focus on improving equity

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[30] *See* 42 C.F.R. 440.130(c). The C.F.R. is searchable, available at: https://www.ecfr.gov/.

[31] CHW SPA information is available at https://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx.

and reducing health disparities. DHCS requires that these programs address the following conditions at a minimum:

- Diabetes
- Cardiovascular disease
- Asthma
- Depression

While all MCPs must offer programs that target the above conditions, MCPs' chronic disease programs should additionally be tailored to the specific needs of each plan's Medi-Cal populations and connected with the PNA and PHM Strategy, along with other community programs (e.g., local health jurisdiction chronic disease initiatives, focus areas for plan community reinvestment programs, data collection efforts by local public health and community organizations).

g. Programs to Address Maternal Health Outcomes

Improving maternal health is one of the DHCS CQS' Bold Goals, which specifically seeks to improve maternity outcomes and birth equity, including access to prenatal and postpartum care. DHCS also introduced the doula benefit on January 1, 2023, to improve culturally competent birth care. PHM programs offered by MCPs have a key role to play in improving outcomes in this area by supporting quality improvement and health disparity reduction efforts with their network providers and addressing systemic discrimination in maternity care, particularly for Black, Native American, and Pacific Islander birthing persons.

MCPs must continue to meet all requirements for pregnant individuals, including covering the provision of all medically necessary services for pregnant women, implementing and administering a comprehensive risk assessment tool that is comparable to the American College of Obstetricians and Gynecologists (ACOG) and standards per Title 22 C.C.R. Section 51348 developing individualized care plans to include obstetrical, nutrition, psychosocial, and health education interventions, and providing appropriate follow-ups.[32,33,34] Future guidance will be issued for MCPs regarding best practices to address maternal health outcomes. Comprehensive Perinatal Service Program (CPSP) standards per Title 22 C.C.R. Section 51348 developing individualized care plans to include obstetrical, nutrition, psychosocial, and health education interventions, and providing appropriate follow-ups.[35,36,37] Future

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[35] 2022 Medi-Cal Managed Care Contract and PL 12-003.
[36] Section 1902(e)(5) of the Social Security Act 6; 42 C.F.R. § 435.170. The Centers for Medicaid and CHIP Services, SHO #21-007.
[37] Effective April 1, 2022, DHCS extended the postpartum care coverage period for currently eligible and newly eligible pregnant individuals. The American Rescue Plan

guidance will be issued for MCPs regarding best practices to address maternal health outcomes.

h. PHM for Children

All children under the age of 21 enrolled in Medicaid are entitled under federal and state law to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, which requires that children enrolled in Medi-Cal receive all screening, preventive, and medically necessary diagnostic and treatment services, regardless of whether the service is included in the Medicaid State Plan or available to adults.

MCPs must meet requirements outlined in the Other Population Health Requirements for Children and the Services for Members under 21 sections of the Amended 2023 MCP Contract:

- Ensure all members under 21 receive an IHA within 120 calendar days of enrollment or within the schedule for children age 18 months and younger, whichever is sooner.
- Provide preventive health visits, including age-specific screenings, assessments, and services, at intervals consistent with the AAP Bright Futures periodicity schedule, and immunizations specified by the Advisory Committee on Immunization Practices (ACIP) childhood immunization schedule.
- Ensure that all medically necessary services, including those that are not covered for adults, are provided as long as they could be Medicaid-covered services.
- Coordinate health and social services for children between settings of care and across other MCPs and delivery systems. Specifically, MCPs must support children and their families in accessing medically necessary physical, behavioral, and dental health services, as well as social and educational services.
- Actively and systematically promote EPSDT screenings and preventive services to children and families.

MCPs must ensure EPSDT is provided to all children and youth as part of their PHM Program, including BPHM, CCM, and ECM. Starting in 2024, as part of MCPs' annual PHM Strategy submission, MCPs are required to review the utilization of children's preventive health visits and developmental screenings and outline their strategies for improving access to those services, as well as articulate and track how BPHM may be deployed to ensure any follow-up and care coordination needs identified from screenings are delivered. For example, BPHM should ensure that all children with abnormal vision screenings receive glasses or that all children with an abnormal developmental screen receive additional required testing. As part of BPHM, MCPs

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Act (ARPA) Postpartum Care Expansion (PCE) extends the coverage period from 60 days to 365 days (one year) for individuals eligible for pregnancy and postpartum care services in Medi-Cal and the Medi-Cal Access Program (MCAP). ARPA PCE coverage includes the full breadth of medically necessary services during pregnancy and the extended postpartum period.

continue to be required to meet all EPSDT requirements related to timely access to services.

In addition, to support children enrolled in Medi-Cal in accessing and receiving wellness and prevention programs, starting in 2024, MCPs will also be required to enter into MOUs with WIC providers. Then starting in 2025, MCPs will be required to enter into MOUs with First 5 programs and providers and every Local Education Agency (LEA) in each county within their service area for school-based services to strengthen provision of EPSDT within schools.

2) Care Management Programs

a. Complex Care Management (CCM)

CCM equates to "Complex Case Management," as defined by NCQA. MCPs are already required to provide CCM. MCPs will continue to be required to provide CCM in 2023, in line with the requirement that all MCPs must meet NCQA PHM standards on January 1, 2023.

CCM is a service for MCP members who need extra support to avoid adverse outcomes but who are not in the highest risk group designated for ECM. CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs, with a goal of regaining optimum health or improved functional capability in the right setting and in a cost-effective manner.

Following NCQA's requirements, MCPs must consider CCM to be an opt-out program – (i.e., members may choose not to participate in CCM if it is offered to them), and MCPs may delegate CCM to providers and other entities who are themselves NCQA-certified.

Required CCM Elements and Processes:

In accordance with the Care Management Programs section of the Amended 2023 MCP Contract and in line with NCQA CCM requirements, MCPs must comply with the following CCM requirements:

i. Eligibility

CCM is a service intended for higher- and medium-rising-risk members and is deliberately more flexible than ECM. MCPs are allowed to determine their own eligibility criteria (within NCQA guardrails[38]) based on the risk stratification process outlined above and local needs identified in the PNA.

ii. Core Service Components:

CCM must include:

1) Comprehensive Assessment and Care Plan

   As in ECM, CCM must include a comprehensive assessment of each member's condition, available benefits, and resources (including Community Supports), as well as development and implementation of a Care Management Plan (CMP) with goals, monitoring, and follow-up.

[38] NCQA 2021 Health Plan Accreditation PHM Standards. PHM 5: Complex Case Management.

2) Services and Interventions

CCM must include a variety of interventions for members who meet the differing needs of high and medium-/rising-risk populations, including:

- Care coordination focused on longer-term chronic conditions
- Interventions for episodic, temporary member needs
- Disease-specific management programs (including, but not limited to, asthma and diabetes) that include self-management support and health education
- Community Supports, if available and medically appropriate, and cost-effective

CCM must also include BPHM as part of the care management provided to members. For children and youth under age 21, CCM must include EPSDT; all medically necessary services, including those that are not necessarily covered for adults, must be provided as long as they could be Medicaid-covered services.

iii. Care Manager Role

1) Assignment of a CCM Care Manager

MCPs must assign a care manager for every member receiving CCM. Following NCQA's requirements, MCPs may delegate CCM to providers and other entities who are themselves NCQA-certified. PCPs may be assigned as care managers when they are able to fulfill all CCM requirements.

If multiple providers perform separate aspects of care coordination for a member, the MCP must:

- Identify a care manager
- Communicate the identity of the care manager to all treating providers and the member
- Maintain policies and procedures to:
    - Ensure compliance and non-duplication of medically necessary services.
    - Ensure delegation of responsibilities between the MCP and the member's providers meets all care management requirements.

MCPs must provide the member's PCP with the identity of a member's assigned care manager (if the PCP is not assigned to this role) and a copy of the member's CMP.

2) Care Manager Responsibilities

CCM care managers are required to ensure all BPHM requirements and NCQA CCM standards are met. This includes conducting assessments of member needs to identify and close any gaps in care and completing a CMP for all members receiving CCM. CCM care managers must also ensure communication and information sharing on a continuous basis and facilitate access to needed services for members, including Community Supports, and across physical and behavioral health delivery systems. MCPs should provide assistance with navigation and referrals, such as to CHWs or community-based social services.

b. Enhanced Care Management (ECM)

ECM, which went live in January 2022, is a new statewide managed care benefit that addresses the clinical and nonclinical needs of Medi-Cal's highest-need members through intensive coordination of health and health-related services.[39] For detailed requirements and implementation timeline for ECM, please refer to the Finalized ECM and Community Supports MCP Contract Template and ECM Policy Guide.

ECM is community-based, interdisciplinary, high touch, person-centered, and provided primarily through in-person interactions. MCPs are required to contract with "ECM Providers," existing community providers such as FQHCs, Counties, County behavioral health providers, Local Health Jurisdictions, Community Based Organizations (CBOs), and others, who will assign a Lead Care Manager to each member. The Lead Care Manager meets members wherever they are – on the street, in a shelter, in their doctor's office, or at home. ECM eligibility is based on members meeting specific "Populations of Focus" criteria. These Populations of Focus are going live in phases throughout 2022 and 2023.

For children and youth under age 21, CCM must include EPSDT; all medically necessary services, including those that are not necessarily covered for adults, must be provided as long as they could be Medicaid-covered services.

Starting in Q2 2022 and extending for at least three years, DHCS instituted MCP quarterly reporting requirements to monitor the implementation of ECM. DHCS monitors outcomes for the group served by ECM and evaluates whether and how the existing Populations of Focus definitions and policies may be improved over time to ensure that the ECM benefit continues to serve those with the highest needs.

ECM and CCM Overlap Policy and Delegation

An individual cannot be enrolled in ECM and CCM at the same time; rather, CCM is on a care management continuum with ECM. CCM can be used to support members who were previously served by ECM, are ready to step down, and who would benefit from CCM; but not all members in CCM previously received ECM, and not all members who step down from ECM require CCM. DHCS encourages MCPs to work with providers to contract for a care management continuum of ECM and CCM programs, wherever possible, including as a way to maximize opportunities for members to step down from ECM to CCM or BPHM under the care of a single provider.

3) *(Updated October 2023)* Transitional Care Services (TCS)

Care transitions are defined as a member transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or long-term care (LTC) settings.

[39] ECM requirements are contained in the ECM Policy Guide and website. This document does not alter or add to ECM program design or requirements.

Under PHM and in line with CalAIM, MCPs are accountable for providing strengthened TCS beginning on January 1, 2023 and fully implemented for all members by January 1, 2024 across all settings and delivery systems, ensuring members are supported from discharge planning until they have been successfully connected to all needed services and supports. This includes critical TCS tasks, such as ensuring that medication reconciliation is completed upon discharge by the discharging facility, and that every member has follow-up care by a provider, including another medication reconciliation completed post-discharge to reduce medication discrepancies, errors, and adverse drug events that are common and can lead to poor outcomes in transitions.[40]

For some of the TCS requirements in this Policy Guide and in the MCP Contract, another entity, such as the care manager or the discharging facility, may be responsible for completing a task. However, the MCPs are ultimately accountable for ensuring all TCS are provided to all transitioning members.[41]

The transitional care policies are consistent with the CQS and are being measured through quality reporting and Key Performance Indicators (KPIs). Moving forward, as future policy guidance is developed to ensure member-centered care during this critical time, additional quality and process measures and reporting will be added to be synergistic with these TCS policies.

Although it is not a required component of TCS at this time, MCPs are strongly encouraged to provide Emergency Department (ED) follow up as part of TCS, especially for the highest risk members, noting that current MCAS quality reporting includes ensuring timely follow-up for members with ED visits for mental health or SUD reasons. In addition, MCPs are strongly encouraged to provide ED follow up as part of TCS for pregnant and postpartum individuals (through 12 months postpartum), given the association of ED visits and maternal morbidity and mortality.

a. Phased TCS Implementation Timeline

For the PHM Program launch on January 1, 2023 and extended implementation by January 1, 2024, each MCP must have an implementation plan to meet the following timeline.[42]

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[40] Poor, or lack of medication reconciliation presents a significant risk for adverse drug events, especially for the highest risk populations. Accurate and timely medication conciliation is a critical element of TCS for ensuring patient safety during transitions of care.

[41] The accountable entity is always the MCP. Responsible entity is the entity who must complete the task or service. For example, MCPs are both the accountable and responsible entity for knowing when their members are admitted, discharged, or transferred. Separately, while MCPs are accountable for ensuring discharging facilities complete their discharge planning process per TCS requirements, the discharge facility is the responsible entity who must perform discharge planning activities.

[42] The MCP is not required to submit the plan for DHCS review, but must provide it to DHCS upon request.

i. By January 1, 2023

- MCPs must know when members are admitted, discharged or transferred for **all members**;
- MCPs must implement timely prior authorizations for **all members**;
- MCPs must assign a care manager/single point of contact who will complete all required TCS responsibilities for **all high-risk transitioning members.**[43]

ii. By January 1, 2024

- In addition to the requirements applying from January 2023, MCPs must add support for TCS for **lower-risk transitioning members**.

The following three sections provide details of each required component: those required for all members in transition; those required for high-risk members in transition; and those required for lower risk members in transition starting in 2024.

b. Required TCS Elements and Processes for All MCP Members (Effective 1/1/23)

i. Admission, Discharge, and Transfer (ADT)

In accordance to Interoperability and Patient Access Final Rule set forth at CMS-9115-F, and the CalHHS Data Exchange Framework (DxF), general acute care hospitals and emergency departments, as defined by HSC §1250, (together "Participating Facilities"), must send admission, discharge, or transfer (ADT) notifications by January 31, 2024 to other organizations that have signed the DxF Data Sharing Agreement if requested in advance of the ADT Event. [44,45] The DxF also encourages but does not require skilled nursing facilities, as defined by HSC §1250 to send admission, discharge, or transfer (ADT) notifications by January 31, 2024. Participating facilities are required to send notification of ADT Events unless prohibited by Applicable Law; they must also accept notification of ADT Events from any other Participant and send notification of ADT Events as requested using a secure method compliant with the Privacy Standards and Security Safeguards Policy and Procedure and in a format acceptable and supported by the requesting Participant.[46] These DxF requirements will support MCPs capabilities to receive ADT notifications from a variety of Participating Facilities.

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[43] For members enrolled in multiple payors, the phased transitional care implementation policy remains the same as outlined in the "Required TCS Elements and Processes, ix. Guidance for Members Enrolled with Multiple Payors" section.

[44] HSC § 130290; CalHHS DxF Technical Requirements for Exchange Policy and Procedure

[45] An ADT Event is defined as an admission, discharge, or transfer.

[46] The Data Exchange Framework requirements do not apply to rehabilitation hospitals, long-term acute care hospitals, acute psychiatric hospitals, critical access hospitals, and rural general acute care hospitals with fewer than 100 acute care beds, state-run acute psychiatric hospitals, and any nonprofit clinic with fewer than 10 health care providers until January 31, 2026.

Under TCS, MCPs are responsible for knowing, in a timely manner, when all of their members have planned admissions, and when they are admitted, discharged, or transferred, and therefore experiencing a transition, through the following mechanisms:

- MCPs are expected to enter agreements with all contracted general acute care hospitals and emergency departments, as defined by HSC §1250 to receive ADT notifications from them whenever their members are admitted, discharged or transferred, and request such notification in advance of the ADT Event, when possible. The 2024 Medi-Cal MCP contract also requires skilled nursing facilities, as defined by HSC §1250 that currently maintain electronic records to send them ADT notifications whenever their members are admitted, discharged or transferred, and request such notification in advance of the ADT Event, when possible. MCPs are responsible for providing up to date Member rosters to their contracted general acute care hospitals, emergency departments, and skilled nursing facilities (together "Participating Facilities") so that such facilities can send notifications to the MCPs whenever one of their members is admitted, discharged or transferred to or from their facility. To meet this expectation, MCPs may receive these ADT notifications from "intermediaries", defined as a health information exchange network, health information organization, or technology vendor that assists a "Participating Facility" in the Exchange of Health and Social Services Information. Example intermediaries might include nationwide networks or frameworks, vendors that provide applicable services, health information organizations including Qualified HIOs, or community information exchanges.
- MCPs are responsible for receiving and using ADT notifications from all contracted "Participating Facilities".
- For all other "Participating Facilities" that the MCPs members are admitted, discharged or transferred from or to, MCPs are expected to identify mechanisms to ensure they are notified by the facility in a timely manner whenever one of their members is admitted, discharged, or transferred. These can include but are not limited to requirements for notification by admitting facilities and institutions directly or leveraging existing prior authorization requests.

ii. Prior Authorizations and Timely Discharges

As referenced in the TCS section of the MCP Contract, MCPs must ensure timely prior authorizations (when possible, prior to discharge) and discharges for all members, which includes, but is not limited to, ensuring that prior authorizations required for a member's discharge are processed in a timely manner, consistent with the policies and timelines outlined in regulations and in APL 21-011, and assisting with placement at facilities within MCPs' provider networks, if necessary. DHCS encourages MCPs to monitor the efficacy of these processes by tracking administrative days, avoidable days, and prior authorization turnaround times at the facility level.

iii. Identification of High- vs. Lower-risk Transitioning Members

Effective January 1, 2024, different minimum TCS requirements apply for high-risk and lower-risk transitioning members as set out below.

"High-risk" transitioning members means **all** members listed under Section D: Understanding Risk, 2) Assessment and Reassessment to Understand Member Needs in this Policy Guide,[47] i.e.:

- Those with LTSS needs;
- Those in or entering CCM or ECM;
- Children with special health care needs (CSHCN);
- Pregnant individuals: for the purposes of TCS, "pregnant individuals" includes individuals hospitalized during pregnancy, admitted during the 12-month period postpartum, and discharges related to the delivery;[48]
- Seniors and persons with disabilities who meet the definitions of "high-risk" established in existing APL requirements;[49]
- Other members assessed as high-risk by RSST.[50]

In addition to these groups, and in recognition of high risk of poor outcomes in transition for MCP members enrolled in multiple payors, those transitioning from SNFs, and those at high risk who are potentially not captured by the above categories, MCPs must **also** consider the following members "high-risk" for the purposes of TCS:

- Any member who has been served by county SMHS and/or DMC or DMC-ODS (if known) within the last 12 months, or any member who has been identified as having a specialty mental health need or substance use disorder by the MCP or discharging facility; [51,52]
- Any member transitioning to or from a SNF;
- Any member that is identified as high risk by the discharging facility and thus is referred or recommended by the facility for high-risk TCS.

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[47] Refer Section D 2) for full definitions and more information.
[48] Additional detailed guidance will be forthcoming on TCS requirements for pregnant and postpartum individuals experiencing a care transition.
[49] APLs 17-012 and 17-013
[50] MCPs should use their own RSST algorithms prior to the PHM Service RSS and risk tiering functionalities become available. However, once the PHM Service RSS and risk tiering functionalities are available, MCPs must use the PHM Service's risk tiers. In addition, MCPs must stratify members at least annually or upon a significant change in the health status or level of the member. For more details, please refer to Section II. PHM Program, D. Understanding Risk 1) RSS and Risk Tiers.
[51] The transitions that qualify include any discharges from any acute care facility, including hospitals, SNFs and inpatient psychiatric facilities. For more information about TCS requirements for the members admitted to inpatient psychiatric facilities when the MCP is not the primary payer, please refer to Section e. Guidance for Members Enrolled with Multiple Payors.
[52] MCPs must utilize SMHS data from DHCS to identify members receiving or eligible for services from a county MHP. For members receiving or eligible for services from a DMC/DMC-ODC, MCPs must make best efforts to identify them through data sharing processes established under the required MOU with DMC-ODS entities (starting in 2024), review of ICD-10 code data, and data from Medi-Cal Rx, in addition to having the discharging facility refer eligible individuals.

iv. MCP Oversight of Facility Discharge Planning Process

TCS requirements build on, rather than supplant, existing requirements on facilities. Hospitals must provide patient-centered discharge planning under their Conditions of Participation (CoPs) for Medicare and Medicaid programs set forth in federal regulation; national Joint Commission accreditation standards; and state statutory requirements; and certain similar requirements apply to SNFs.[53]

Under TCS, MCPs are accountable for providing all TCS in collaboration and partnership with discharging facilities, including ensuring hospitals provide discharge planning as required by federal and state requirements. MCPs must ensure discharging facilities complete a discharge planning process that:

- Engages members, and/or members' parents, legal guardians, or Authorized Representative, as appropriate, when being discharged from a hospital, institution or facility.[54]
- Focuses on the member's goals and treatment preferences during the discharge process, and that these goals and preferences are documented in the medical record.[55]
- Uses a consistent assessment process and/or assessment tools to identify members who are likely to suffer adverse health consequences upon discharge without adequate discharge planning, in alignment with hospitals' current processes. Hospitals are currently already required to identify these members and complete a discharge planning evaluation on a timely basis, including identifying the need and availability of appropriate post-hospital services and documenting this information in the medical record for establishing a discharge plan.[56]
    - For high-risk members, MCPs must ensure the discharging facility shares this information with the MCPs' assigned care manager and that the discharging facilities have processes in place to refer to members to ECM or Community Supports, as needed.
    - For members not already classified as high-risk by the MCP per above definitions under Section iii. Identification of High- vs. Lower-Risk

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[53] The following discharge and transition planning requirements apply to various types of facilities. This list is not exhaustive; it is the responsibility of the discharging facility to ensure they are compliant with all applicable requirements.

- Centers for Medicare and Medicaid (CMS) CoPs requirements set forth in federal regulations include but are not limited to: 42 CFR § 482.43; 42 CFR § 482.24. CMS requirements for LTC facilities include but are not limited to: 42 CFR § 483.21
- State Requirements include, but are not limited to: HSC § 1262.5; Knox-Keene Act KKA CCR Title 28 § 1300.67 (b); HSC § 1373.96; WIC § 14186.3(c)(4);
- Joint Commission Requirements include but are not limited to: PC.04.01.01; PC.04.01.03; PC.04.02.01; PC.02.02.01; RC.02.04.01.

[54] 42 CFR § 482.43; HSC § 1262.5

[55] 42 CFR § 482.43; Joint Commission Requirement: PC.04.01.03

[56] 42 CFR § 482.43; 42 CFR § 482.24; Joint Commission Requirements: RC.02.04.01

Transitioning Members, the discharging facility must have processes in place to leverage the assessment to identify members who may benefit from high-risk TCS services. This process must include referrals to the MCP for:
    - Any member who has a specialty mental health need or substance use disorder.
    - Any member who is eligible for an ECM Population of Focus
    - Any member whom the clinical team feels is high risk and may benefit from more intensive transitional care support upon discharge.
- Ensures appropriate arrangements for post-discharge care are made, including needed services, transfers, and referrals, in alignment with facilities' current requirements.[57]
- Ensures members and their caregivers are informed of the continuing health care requirements through discharge instructions and that this information must be provided in a culturally and linguistically appropriate manner.[58]
    - This must include a medication reconciliation upon discharge that includes education and counseling about the member's medications[59].
- Coordinates care with:
    - **The member's designated family caregiver(s).** The MCP should ensure they are notified of the member's discharge or transfer to another facility.[60]
    - **Post-discharge providers**. The MCP should ensure they are notified and receive necessary clinical information, including a discharge summary in the medical record that outlines the care, treatment, and services provided, the patient's condition and disposition at discharge, information provided to the patient and family, and provisions for follow-up care.[61]

c. Minimum TCS Elements and Processes for High-Risk Members (Effective 1/1/23)

As noted in the TCS section of the MCP Contract, TCS for High-Risk Members is accomplished by ensuring that a single point of contact, herein referred to as a care manager[62], who must assist high-risk members throughout their transition and ensure all required care coordination and follow-up services are complete as described under care manager responsibilities below.

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[57] 42 CFR § 482.43; 42 CFR § 482.24
[58] HSC § 1262.5
[59] This refers to the pre-discharge medication reconciliation. Medication reconciliation should be completed upon discharge by the discharging facility (pre-discharge) and a second reconciliation must be complete after discharge once the member is in their new setting (post-discharge).
[60] HSC § 1262.5
[61] 42 CFR § 482.43; 42 CFR § 482.24; Joint Commission Requirements: RC.02.04.01
[62] A care manager can have a variety of experiences or credentials to support transitional care activities and does not need to be a licensed provider. However, care manager assignment should consider the level of need for each member.

i. Identify the Care Manager Responsible for TCS

Once a member has been identified as being admitted and as being high-risk, the MCP must identify a care manager, who is the single point of contact responsible for providing longitudinal support and ensuring completion of all TCS across all settings and delivery systems, and that members are supported in a culturally and linguistically appropriate manner from discharge planning until they have been successfully connected to all needed services and supports.

For members already enrolled in CCM or ECM at the time of the transition, the MCP must ensure that the member's assigned ECM Lead Care Manager or CCM care manager is that identified care manager and provides all TCS.

"Longitudinal support" means that a single relationship must span the whole transition. For members who do not already have a care manager through ECM or CCM, the MCP may choose either to use its own staff to accomplish this, or to contract with the hospital, the PCP or another appropriate delegate such as an accountable care organization (ACO).[63] DHCS encourages plans to work with their networks to create models of care that do not duplicate work, including the engagement of discharging facilities to take on the full scope of longitudinal TCS.

Many high-risk members in transition will meet criteria for ECM or CCM for the first time on account of the event or condition that necessitated the facility stay. At any time in the TCS process, the discharging facility, or the TCS care manager should screen and refer a member for longer term care management programs (ECM or CCM) and/or Community Supports.

Working with a care manager is optional for members. MCPs must ensure that the member is offered the direct assistance of the care manager, but members may choose to have limited or no contact with the care manager. In these cases, at a minimum, the MCP must ensure that discharging facilities comply with federal and state discharge planning requirements listed above and that the care manager assists in all care coordination among the discharging facility, the PCP, or any other identified follow-up providers, and the follow-up is complete.

ii. Communication of Assignment to the Care Manager

MCPs are required to communicate both with the responsible care manager (or contracted care manager) and with the discharging facility in a timely manner so that the care manager can coordinate with the discharge facility on discharge planning and support access to available services.[64]

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[63] This arrangement for MCP contracted entities to provide TCS is not considered formal delegation and therefore, MCPs would not be subject to requirements outlined in APL 17-004.

[64] In the instance that the care manager is at the facility, the MCP's role is to communicate with the facility.

For high-risk members in transition, their assigned care managers (including ECM and CCM) must be notified within 24 hours of admission, transfer or discharge when an ADT feed is available or within 24 hours of the MCP being aware of any planned admissions, or of any admissions, discharges or transfers for instances where no ADT feed exists (such as for SNF admissions). However, this notification time frame will not apply if the care manager responsible for TCS is notified of the admission, discharge, or transfer through an ADT feed directly.

MCPs must notify the identified responsible care manager of the assignment and of the member's admission status, including the location of admission, and ensure that the discharging facility has the name and contact information, including phone number of the identified care manager. MCPs must also ensure the member has the care manager's contact information. A best practice is for the care manager to work with the discharging facility to incorporate the care manager name and contact number in the discharging facility's discharge document that the member receives.

iii. Care Manager Responsibilities

The care manager responsible for TCS is responsible for coordinating and verifying that high-risk members receive all appropriate TCS, regardless of setting and including, but not limited to, inpatient facilities, discharging facilities, and community-based organizations. As set out above, the hospital/discharging facility's responsibility to perform discharge planning does not supplant the need for TCS, although the TCS responsibility may be fully contracted out to the hospital/facility to allow a single team to perform discharge and TCS. If MCPs contract with or delegate TCS to providers or facilities, MCPs must have a monitoring plan in place to ensure all required TCS are completed.

The care manager is responsible for ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions. While the care manager does not need to perform all activities directly, they must coordinate and ensure completion of following critical TCS tasks:

- **Coordinating with Discharging Facility to ensure member engagement and comprehensive information sharing and coordination of care:** A core responsibility of the care manager is to coordinate with discharging facilities to ensure the care manager fully understands the potential needs and the needed follow-up plans for the member and to ensure the member participates in the care plan and receives and understands information about their needed care. To do this, the care manager must complete the following:
    - Risk Assessment:
        - The care manager must assess member's risk for adverse outcomes to inform needed TCS. This must include, reviewing information from the discharging facility's assessment(s) and discharge planning

process (e.g., the discharge summary). The care manager may supplement this risk assessment as needed through member engagement. During this process, the care manager must also identify members who may be newly eligible for ongoing care management (ECM/CCM), and/or Community Supports and make appropriate referrals.

- Discharge Instructions:
  - Care Managers must receive and review a copy of the discharging facility's discharge instructions given to the member, including the medication reconciliation completed upon discharge by the discharging facility.
  - After discharge, upon member engagement, care manager must review the discharge instructions with the member and ensure that member can have any questions answered.
  - A best practice (not required) is for the care manager to work with the facility to ensure that the care manager's name and contact information are integrated into the discharge documents.
- Discharge Summary and Clinical Information Sharing:
  - Care Managers must receive and review a copy of the discharging facility's discharge summary once it is complete.[65,66]
  - Care Managers must ensure all follow-up providers have access to the needed clinical information from the discharging facility, including the discharge summary.

- **Necessary Post-Discharge Services and Follow-Ups:** Knowing that immediately post-discharge is an especially vulnerable time for high-risk members, support and follow-up post-discharge are critical aspects for the care manager responsible for TCS, including tasks in the MCP contract and as described below:
  - Member Outreach:
    - The identified care manager is responsible for contacting the member within 7 days of discharge (may be sooner) and supporting the member in all needed TCS care identified at discharge, as well as any new needs identified through engagement with the member or their care providers.
  - Ensuring needed post-discharge services are provided and follow-ups are completed, including (but not limited to) by assisting with making follow up provider appointments, to occur within 7 days post-discharge; connecting to the PCP (if different); [67] and arranging transportation.

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[65] 42 CFR § 482.43; 42 CFR § 482.24; Joint Commission Requirements: RC.02.04.01

[66] If the discharge summary is not complete after 30 days, the care manager is not responsible for its receipt.

[67] For members who have not had a visit with their PCP in the last 12 months, MCPs are responsible for providing health education and connection to the PCP (MCP Contract, Section 4.3.8 Basic Population Health Management, A. 8); for high-risk members in transition, the care manager should perform this function as part of TCS.

- SUD and mental health treatment initiation or continuation for those who have an identified SUD or Mental health condition.
- Medication reconciliation, post discharge:[68]
  - Care manager must ensure this is complete after individual is discharged. This can be done by the follow-up provider, such as the PCP, or by the care manager if they hold an appropriate license, or by another team member on the care manager's team that has appropriate license, in a manner that is consistent with California's licensing and scope of practice requirements, as well as applicable federal and state regulations.
- Completion of referrals to social service organizations, and referrals to necessary at-home services (DME, home health, etc.).
- Connection to community supports as needed.
- For members who are transferred to/from nursing facilities, ensure completion of care coordination tasks in the contract including:
  - Ensure outpatient appointments are scheduled prior to discharge;
  - Verify that Members arrive safely and have their medical needs met;
  - Follow-up with Members to ensure all TCS needs and requirements have been met.

iv. End of TCS for High-Risk Members

TCS for high-risk members extends until the member has been connected to all the needed services, including but not limited to all that are identified in the discharge risk assessment or discharge planning document. TCS for high-risk members should always extend at least 30 days post-discharge. If the MCP has delegated TCS, the MCP must ensure that the delegate follows and coordinates services for the member until all aforementioned activities are completed. For those who have ongoing unmet needs, eligibility for ECM or CCM and/or Community Supports should be reconsidered.

For members who may not respond to the MCP's outreach attempts or did not attend scheduled follow-up ambulatory visits, the MCP must make reasonable effort to ensure members are engaged and that the follow-up ambulatory visits are completed. For example, the care manager must ensure the members know that TCS support is available for at least 30 days or use CHWs to conduct outreach and attempt to engage the members in person.

For members with multiple care transitions within a 30-day period, the MCP must ensure the same care manager is assigned to support them through all these transitions. If the second transition is within 7 days of the first transition, then the care manager must ensure the follow up visit is completed within 7-days post discharge after the last transition. The care manager must also provide TCS support for at least 30

[68] This refers to the post-discharge medication reconciliation. Medication reconciliation should be completed upon discharge by the discharging facility (pre-discharge) and a second reconciliation must be complete after discharge once the member is in their new setting (post-discharge).

days after the last transition. These members should be considered for ECM/CCM and/or Community Supports eligibility.

d. Minimum TCS Elements and Processes for Lower-Risk Members (Effective 1/1/24)

Lower-risk members in transition are defined as those not included in the high-risk definition above. MCPs are required to meet contract requirements for lower-risk members as outlined in the TCS section of the MCP Contract with the specific operational requirements listed in this Policy Guide, starting on January 1, 2024. **For lower-risk members, a single care manager managing the entire transition is not required**. Rather, the MCP is required to ensure that (1) the member has access to a specialized TCS team (at the MCP or a delegate)[69] for a period of at least 30 days from the discharge; and (2) ambulatory follow-up occurs.

i. Dedicated Team/Phone Number for Member Contact and Support

The MCP must ensure that it has a dedicated team and phone number to support transitioning members telephonically when they request help. The required features of this dedicated support service are as follows:

- **Minimum Requirements for the Dedicated TCS Team:** The MCP's TCS team must meet the following requirements:
  - First point of member contact may be a trained customer service representative or similar unlicensed team member. However, the team must consist of additional staff and support to provide an escalation pathway to allow the member to reach care management/clinical staff, who can address any of their issues that require licensed care providers. This may include nurse care managers or physicians.
  - The team must be able to access discharge planning documents, if needed, to assist members with questions regarding care at the discharging facility, including medication changes.
  - The team must be able to provide assistance for any TCS need, including (but not limited to) help with access to ambulatory care, appointment scheduling, referrals/handoffs to needed social services or community-based resources, including arranging NEMT.
  - The team must be able to place and coordinate referrals to longer term care management programs (ECM/CCM) and/or Community Supports at any point during the transition.
- **Minimum Requirements for the Phone Line:**
  - MCPs must offer, at minimum, dedicated telephonic support services for members experiencing a transition of care. MCPs may leverage existing member support telephone services to meet this requirement. MCPs are encouraged to offer additional modalities beyond telephonic support services such as text-messaging or in-person CHW supports, as appropriate to members.

[69] This arrangement for MCP contracted entities to provide TCS is not considered formal delegation and therefore, MCPs would not be subject to requirements outlined in APL 23-006.

    - During business hours, plans must ensure that members are able to connect with a live team dedicated to TCS. If using an automated phone tree under "member services" or similar, transitioning members must not have to select more than one option before reaching this dedicated line.
    - Outside of business hours, the plan must ensure that:
        - Members are referred to emergency services if needed;
        - Members can leave a message;
        - Messages are shared with the dedicated TCS team. A TCS team staff must respond to members within 1 business day after the initial phone call.
- **Member Communication of TCS Support:**
    - MCPs must ensure lower risk members in transition receive direct communication about the dedicated TCS team and phone line and how to access it. MCPs must make best efforts to ensure members receive this information no later than 24 hours after plans are notified of the discharge.
    - Acceptable methods of notification include text messaging, automated phone calls, incorporating into discharge documents, and letters (either as supplemental to other efforts or if no other effort was effective). Electronic platform-based communication/bidirectional text messaging may also be used but must not take the place of the dedicated line. Plans may choose to use more than one method of notification.

ii. Necessary Post-Discharge Services and Follow-Ups for Lower-Risk Members

In addition to the dedicated call line, the MCP must ensure that each lower-risk member in transition completes a follow-up ambulatory visit with a physician or advanced practice provider (with prescribing authority) within 30 days of discharge for necessary post-discharge care and services, such as medication reconciliation post-discharge, which is a critical TCS requirement. In addition, for any members who have open preventive services care gaps or have not had a PCP visit within 12 months, MCPs must ensure that each lower-risk member has PCP follow up in addition to any other non-PCP ambulatory visits that may be needed. The MCP is strongly encouraged to support members' follow up visits with their PCPs/ambulatory providers within 14 days of discharge. If a PCP or ambulatory follow up visit has not been completed within 14 days, then MCPs are encouraged to use CHWs through the CHW benefit[70] or partner with the member's PCP to facilitate member outreach and engagement by the PCP to facilitate the completion of the PCPs/ambulatory visit within 30 days post-discharge.

iii. End of TCS for Lower-risk Members

MCPs must continue to offer TCS support through a dedicated telephonic team for at least 30 days post-discharge. In addition to accepting referrals to longer term care management at any point during the transition, MCPs must use data including any information from admission, to identify newly qualified members for outreach and enrollment into ECM/CCM and/or Community Supports.

[70] APL 22-016

e. Guidance for Members Enrolled with Multiple Payors

Consistent with the policy that the MCP is responsible for coordinating whole-person care, even for services or benefits carved-out of Medi-Cal managed care, the MCP or its contracted care manager is responsible for ensuring transitional care coordination for its members as outlined above. This also applies in instances where the MCP is not the primary source of coverage for the triggering service (e.g., hospitalization for a Medicare FFS dual-eligible member, or an inpatient psychiatric admission covered by a County MHP). MCPs and county MHPs must share necessary data and information to coordinate care for TCS per MHP-MCP MOU requirements.[71]

For all members enrolled with multiple payors undergoing any transition, MCPs must know when their members are admitted, discharged, or transferred; MCPs must notify existing Medi-Cal care managers (ECM or CCM) of admissions, discharges, and transfers; and MCPs must conduct prior authorizations and coordinate, in a timely manner, for any Medi-Cal covered benefits where Medi-Cal is the primary payor.[72] However, there are specific modifications to the assignment of a care manager and care manager responsibilities as follows:

Requirements for Members Dually Eligible for Medi-Cal and Medicare in Medicare Medi-Cal Plans or Dual-Eligible Special Needs Plans (D-SNPs):

For admissions, transfers and discharges involving dually eligible members enrolled in Medicare Medi-Cal Plans (MMPs), or members enrolled in any other D-SNP, the MMP/ D-SNP is responsible for coordinating the delivery of all benefits covered by both Medicare and Medi-Cal, including services delivered via Medi-Cal Managed Care and Medi-Cal FFS. Thus, the Medi-Cal MCP is not responsible for assigning a transitional care manager/having dedicated TCS team/phone number or any transitional care responsibilities for dually eligible beneficiaries enrolled in MMPs or D-SNPs. However, if a member has an existing ECM or CCM care manager, the MCP is responsible for notifying that care manager of the admission, discharge or transfer.

For admissions, transfers and discharges involving MCP members dually eligible for Medi-Cal and Medicare enrolled in Medicare FFS or MA plans (except D-SNPs), MCPs remain responsible for ensuring all transitional care requirements are complete, including assigning or delegating a care manager or having a dedicated TCS team/phone number.

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[71] MHP-MCP MOU Template, 11. Data Sharing and Confidentiality. a. Data Exchange; CalAIM Data Sharing Authorization Guidance VERSION 2.0 June 2023 available at: https://www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Data-Sharing-Authorization-Guidance-Version-2-Draft-Public-Comment.pdf.

[72] Examples of services where MCP is the primary payor for individuals dually eligible for Medicare and Medi-Cal include but are not limited to CBAS, LTC services, transportation to medical appointments, hearing aids and routine eye exams (when not covered by a Medicare Advantage (MA) plan), Community Supports, and ECM.

Requirements for When County MHPs or DMC-ODS Are the Primary Payors:
For members who are admitted for an acute psychiatric hospital, psychiatric health facility, adult residential, or crisis residential stay, where the county MHP is the primary payor, and for members who are admitted for residential SUD treatment, including residential withdrawal management, where DMC-ODS is the primary payor, MHPs or DMC-ODS are primarily responsible for coordination of care with the member upon discharge. However, MHPs and DMC-ODS have limited access/ability to coordinate across the MCP or physical health care needs, therefore:

- Given these members are considered high-risk as defined in Section c. 3. iii. Identification of High- vs. Lower-risk Transitioning Members, in addition to the required TCS elements and processes for all MCP members outlined above (e.g., knowing when members are admitted, discharged, and transferred and processing prior authorizations in a timely manner), MCPs will also be required to assign or contract with a care manager to coordinate with behavioral health or county care coordinators, ensure physical health follow-up needs are met, and assess for additional care management needs or services such as ECM, CCM, and/or Community Supports.
- As outlined in the BPHM section above, in 2024 MCPs are required to have MOUs with required entities, including County MHPs and DMC-ODS, to facilitate care coordination and ensure non-duplication of services. Under the MOUs, MCPs are required to develop a process with MHPs and DMC-ODS entities to coordinate transitional care services for members.

Additional Requirements for Inpatient Medical Admission with Transfer to Inpatient Psychiatry or Residential Rehab:
For members who are admitted initially for a medical admission and transferred or discharged to a behavioral health facility, including a SUD psychiatric or a residential rehab facility (including intra-hospital transfers to a psychiatric-distinct unit of a hospital):

- MCPs are responsible for all TCS during the transfer/discharge to the behavioral health facility.
- TCS for this transfer/discharge end once the member is admitted to the behavioral health facility and connected to all needed services, including care coordination. In these instances, this likely will be after the member arrives at the behavioral health facility, medication reconciliation has occurred, and all information sharing between institutions is complete.
- After the member's treatment at the behavioral health facility is complete and the member is ready to be discharged or transferred, MCPs must follow the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above.

f. DHCS Monitoring of TCS

If the MCP contracts with or delegates to facilities or providers to provide full scope or specific components of TCS, the MCP must have robust monitoring and enforcement

process in place to hold facilities or providers accountable for providing all required TCS outlined above.
DHCS will monitor MCPs' TCS implementation through specific PHM Monitoring KPIs, including "Percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7-days post discharge" and "Percentage of acute hospital stay discharges which had follow- up ambulatory visit within 7 days post hospital discharge", as well as member outcomes through specific quality measures. More details on DHCS monitoring of TCS implementation will be forthcoming including how DHCS will monitor timely authorizations and discharges and 30-day post-discharge follow-up for lower-risk members, in addition to a greater focus on primary care engagement or use of services such as ECM, CCM, or Community Supports for those who have had a transition. For additional details and future guidance on DHCS monitoring of TCS, please see Section III Monitoring Approach for Implementation of the PHM Program.

III. Monitoring Approach for Implementation of the PHM Program

The purpose of DHCS' PHM Program monitoring approach is to assess the overall implementation, operations, and effectiveness of each MCP's PHM program and understand the impact on outcomes and health equity over time.

To monitor MCPs' PHM programs, DHCS will review the holistic performance of PHM Program implementation at each MCP through monitoring performance across multiple PHM categories. These categories are organized by the following monitoring domains: PHM program areas/themes, populations, and cross-cutting priorities. Core aspects of the PHM program areas include basic population health, RSST, CCM, ECM, and TCS. Specific populations for which DHCS will be monitoring the implementation of the PHM Program in 2023 include Children and Youth, Birthing Populations, and Individuals with Behavioral Health Needs, which align with the clinical focus areas in DHCS's CQS. DHCS anticipates monitoring the implementation of the PHM Program for seniors and dual-eligible members as a population of focus in the future. In 2023, DHCS will also be monitoring equity across all monitoring domains and categories. The monitoring domains and detailed categories are found in Table 1.

Table 1. PHM Monitoring Domains and Categories

Monitoring Domains	Categories
PHM Program Areas/Themes	Basic Population Health Management (BPHM)
	• Prevention Services
	• Primary Care Engagement/ Appropriate Utilization
	• Chronic Disease Management
	• CHW Integration

	Risk Stratification Segmentation and Tiering (RSST)
	Complex Care Management (CCM)
	Enhanced Care Management (ECM)
	Transitional Care Services (TCS)
Populations	Children and Youth
	Birthing Populations
	Individuals with Behavioral Health Needs
Cross Cutting Priorities	Equity (include all stratified measures)

Within each category, DHCS will identify and review a set of quality measures, and where needed to supplement these quality measures, DHCS will also review key performance indicators (KPIs). Existing quality and performance improvement processes, such as the Medi-Cal Managed Care Accountability Set (MCAS) and the CalAIM Incentive Payment Program (IPP), assess each measure individually and, as applicable, applies rewards or penalties against individual measure performance within a specific time period. For PHM monitoring, DHCS will not be reviewing each measure individually, but will instead review the overall picture revealed by the performance across all the measures within a category to understand if core aspects of a MCP's PHM program are working as intended. The intent is also to look over time — using early measure performance as a baseline and looking for improvements, as well as identifying outliers. By reviewing each monitoring category, DHCS will be able to spot priority issue areas that require direct DHCS follow-up with MCPs and identify areas in the PHM Program requirements that need additional DHCS guidance or clarifications.

DHCS will conduct routine engagement with MCPs throughout each year on MCPs' PHM programs to ensure regular, bidirectional communication on implementation challenges and successes. DHCS will use these meetings to discuss PHM monitoring data, gather additional information about how the MCP is doing on PHM, and deliver key messaging around expectations for the PHM Program. In addition, DHCS expects that MCPs will use its own monitoring approaches to regularly assess its own PHM program.

The PHM monitoring approach will evolve over time and add KPIs and quality measures to monitoring categories. DHCS may also add additional populations or cross cutting priorities. Once the PHM Service is fully implemented, the monitoring strategy will change to leverage its reporting and analytics functionalities.

Monitoring Measures

To take a more holistic view across PHM while also minimizing reporting burden on MCPs, DHCS identified existing quality measures to monitor MCPs' PHM Programs' impact on outcomes and access to services. DHCS is leveraging existing data that

DHCS already has from MCAS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) quality measures reported through the annual quality and performance improvement process as well as through its Core Set reporting processes.

Where quality measures by themselves were insufficient to fully monitor a category, DHCS identified a limited number of new high-priority KPIs. MCPs will be required to report these KPIs at the plan level on a quarterly basis.

PHM Program monitoring will begin in Q3 2023. MCPs will submit their first KPIs in August 2023 from Q1 and Q2 2023. While audited 2023 quality measure data will not be available until 2024, DHCS will begin looking at quality measures in 2023, using 2022 data.

A. Quality Measures

DHCS will review existing data from a subset of MCAS and CAHPS quality measures reported through the existing annual quality and performance improvement process to monitor MCPs' PHM Programs. See Table 2 below for a list of the quality measures DHCS will review for PHM monitoring; the table also indicates which quality measures will be used for the children and youth, birthing populations, and individuals with behavioral health needs population-level analyses. MCPs will not need to report any additional quality measure data at this time.

Under the existing quality process, MCPs must stratify certain quality measures per NCQA by race and ethnicity (as noted in Table 2 below); DHCS will review MCPs' stratified performance on these measures as part of its PHM monitoring approach.

MCPs currently submit quality measure data to DHCS at the reporting unit level[73] in January-May, and audited measure data are released to DHCS in July for internal validation. For PHM monitoring, DHCS will aggregate the existing data from the below quality measures to be able to review at the plan level. For more details about the quality measures, please see Appendix 5: List of Quality Measures and Descriptions for PHM Monitoring Approach. DHCS may review additional existing MCAS and CAHPS measures in the future.

[73] DHCS defines a "reporting unit level" as a single county, a combined set of counties, or a region as determined and pre-approved by DHCS.

Table 2. PHM Monitoring Quality Measures

Quality Measures to be Reviewed for PHM Monitoring Starting in August 2023	Stratified by race/ethnicity per NCQA categorizations	Reviewed for Children and Youth population analysis	Reviewed for Birthing population analysis	Reviewed for Individuals with Behavioral Health Needs population analysis
Depression Screening and Follow-Up for Adolescents and Adults	✓	✓		✓
Depression Remission or Response for Adolescents and Adults		✓		✓
Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits	✓	✓	✓	
Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits	✓	✓		
Child and Adolescent Well-Care Visits	✓	✓		
Developmental Screening for the First Three Years of Life		✓		
Lead Screening for Children		✓		
Childhood Immunization Status: Combination 10	✓	✓		
Immunizations for Adolescents: Combination 2	✓	✓		
Topical Fluoride for Children		✓		
Prenatal Depression Screening and Follow Up			✓	✓
Postpartum Depression Screening and Follow Up			✓	✓
Colorectal Cancer Screening	✓			

Quality Measures to be Reviewed for PHM Monitoring Starting in August 2023	Stratified by race/ethnicity per NCQA categorizations	Reviewed for Children and Youth population analysis	Reviewed for Birthing population analysis	Reviewed for Individuals with Behavioral Health Needs population analysis
Chlamydia Screening in Women				
Breast Cancer Screening	✓			
Cervical Cancer Screening				
Ambulatory Care: Emergency Department (ED) Visits		✓		
Adults' Access to Preventive/Ambulatory Health Services				
Asthma Medication Ratio	✓			
Controlling High Blood Pressure	✓			
Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (>9%)	✓			
Antidepressant Medication Management: Acute Phase Treatment				✓
Antidepressant Medication Management: Continuation and Maintenance Phase				✓
Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase		✓		✓
Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase		✓		✓

Quality Measures to be Reviewed for PHM Monitoring Starting in August 2023	Stratified by race/ethnicity per NCQA categorizations	Reviewed for Children and Youth population analysis	Reviewed for Birthing population analysis	Reviewed for Individuals with Behavioral Health Needs population analysis
Pharmacotherapy for Opioid Use Disorder	✓			✓
Follow-Up After ED Visit for Mental Illness – 30 days	✓			✓
Follow-Up after ED Visits for Substance Use – 30 days	✓			✓
Plan All-Cause Readmissions	✓			
Potentially Preventable 30-day Post-Discharge Readmission	✓			
Prenatal and Postpartum Care: Postpartum Care	✓		✓	
Prenatal and Postpartum Care: Timeliness of Prenatal Care	✓		✓	
Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate			✓	
CAHPS: Getting Needed Care (Adult and Child)		✓		
CAHPS: Getting Care Quickly (Adult and Child)		✓		

B. KPIs

DHCS will also review a set of high-priority KPIs for more frequent, active, and real-time monitoring of program operations and effectiveness. KPIs are intended to be indicators that plans should already track internally to manage their own performance. MCPs must report KPIs at the plan level on a quarterly basis. DHCS may request more granular county or member-level data if any issues arise during the plan-level review. Additional KPIs may be added in the future once the PHM Service is implemented. Data that MCPs already report on for the ECM Quarterly Implementation Monitoring Reporting

(QIMR) and the CalAIM Incentive Payment Program (IPP) will be leveraged for some KPIs to decrease MCP reporting burden. **Therefore, MCPs will only be required to report on five new KPIs specific to PHM monitoring.**

While MCPs are required to report the five new KPIs to DHCS at the plan level on a quarterly basis, DHCS expects that MCPs calculate all of the KPIs at the member-level on a monthly basis to monitor their own performance and have a real-time understanding of the operations and effectiveness of their PHM program.

DHCS will calculate the KPIs at a plan level using existing data from DHCS where possible and match against what MCPs submit on a quarterly basis. If there are inconsistencies, DHCS will probe further and request member-level data from MCPs if needed.

See Table 3 below for a list of the KPIs DHCS will review for PHM monitoring; the table also indicates which KPIs will be used for the children and youth, birthing populations, and individuals with behavioral health needs population-level analyses. KPIs for the RSST PHM monitoring category will not be implemented until the PHM Service RSST functionalities are available. For more details about the KPIs, please see Appendix 4: List of KPIs and Technical Specifications for PHM Monitoring Approach.

Table 3. PHM Monitoring KPIs

PHM Monitoring Categories	KPIs to be Reported Starting in August 2023	For Children and Youth Population Analysis	For Individuals with Behavioral Health Needs population analysis	Included in IPP Measure Set	Included in ECM QIMR
BPHM – Primary Care Engagement /Appropriate Utilization	Percentage of members who had more ED visits than primary care visits within a 12-month period	✓			
	Percentage of members who had at least one primary care visit within a 12-month period	✓			
	Percentage of members with no ambulatory or preventive visit	✓			

PHM Monitoring Categories	KPIs to be Reported Starting in August 2023	For Children and Youth Population Analysis	For Individuals with Behavioral Health Needs population analysis	Included in IPP Measure Set	Included in ECM QIMR
	within a 12-month period				
BPHM – CHW Integration	Percentage of members who received CHW benefit			✓	
Complex Care Management (CCM)	Percentage of members eligible for CCM who are successfully enrolled in the CCM program	✓			
Enhanced Care Management (ECM)	Percentage of members enrolled in ECM				✓
	Percentage of members enrolled in ECM "Individuals Experiencing Homelessness" Population of Focus (POF)				✓
	Percentage of members enrolled in ECM "Individuals At Risk for Avoidable Hospital or ED Utilization" POF				✓
	Percentage of members enrolled in ECM "Individuals with Serious Mental Health and/or Substance Use		✓		✓

PHM Monitoring Categories	KPIs to be Reported Starting in August 2023	For Children and Youth Population Analysis	For Individuals with Behavioral Health Needs population analysis	Included in IPP Measure Set	Included in ECM QIMR
	Disorder (SUD) Needs" POF				
	Percentage of members enrolled in ECM “Individuals Transitioning from Incarceration" POF				✓
	Percentage of members enrolled in ECM "Adults Living in the Community and At Risk for LTC Institutionalization " POF				✓
	Percentage of members enrolled in ECM "Adult Nursing Facility Residents Transitioning to the Community" POF				✓
	Percentage of members enrolled in all ECM Children and Youth POFs	✓			✓
	Percentage of members enrolled in ECM “Homeless Families or Unaccompanied Children/Youth Experiencing	✓			✓

PHM Monitoring Categories	KPIs to be Reported Starting in August 2023	For Children and Youth Population Analysis	For Individuals with Behavioral Health Needs population analysis	Included in IPP Measure Set	Included in ECM QIMR
	Homelessness" POF				
	Percentage of members enrolled in ECM "Children and Youth At Risk for Avoidable Hospital or ED Utilization" POF	✓			✓
	Percentage of members enrolled in ECM "Children and Youth with Serious Mental Health and/or SUD Needs" POF	✓			✓
	Percentage of members enrolled in ECM "Children and Youth Transitioning from Incarceration" POF	✓			✓
	Percentage of members enrolled in ECM "Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition" POF	✓			✓

PHM Monitoring Categories	KPIs to be Reported Starting in August 2023	For Children and Youth Population Analysis	For Individuals with Behavioral Health Needs population analysis	Included in IPP Measure Set	Included in ECM QIMR
	Percentage of members enrolled in ECM "Children and Youth Involved in Child Welfare" POF	✓			✓
Transitional Care Services (TCS)	Percentage of contracted acute care facilities from which MCPs receive ADT notifications			✓	
	Percentage of contracted skilled nursing facilities from which MCPs receive ADT notifications			✓	
	Percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7-days post discharge				
	Percentage of acute hospital stay discharges which had follow-up ambulatory visit within 7 days post hospital discharge			✓	

MCPs will be required to stratify and report these five new KPIs by race, ethnicity, language, and age on a plan-level as specified in Appendix 5: PHM Monitoring KPI Technical Specifications:

- Percentage of members who had more ED visits than primary care visits within a 12-month period;
- Percentage of members who had a primary care visit within a 12-month period;
- Percentage of members with no ambulatory or preventive visit within a 12-month period;
- Percentage of members eligible for CCM who are successfully enrolled in the CCM program; and
- Percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post discharge.

While MCPs are required to report these stratified KPIs to DHCS at the plan level on a quarterly basis, DHCS expects that MCPs stratify the KPIs at the member-level on a monthly basis to monitor their own performance particularly with regard to health equity.

For the three KPIs that DHCS has internal data on (percentage of members who had more ED visits than primary care visits within a 12-month period; percentage of members who had a primary care visit within a 12- month period; and percentage of members with no ambulatory or preventive visit within a 12-month period), DHCS will calculate stratifications using the same technical specifications in Appendix 5: List of KPIs and Technical Specifications for PHM Monitoring Approach. Then DHCS will match these internal stratifications with what MCPs submit on a quarterly basis. If there are inconsistencies, DHCS will probe further and request member-level data from MCPs if needed.

MCPs will not be required to adjust stratification approaches for KPI data reported through IPP reporting or ECM QMIR.

Starting in 2024, DHCS will begin to measure referrals made by the members' assigned transitional care managers resulting in enrollment into CCM as well as the ECM "Adults Living in the Community and At Risk for LTC Institutionalization" POF, "Adult Nursing Facility Residents Transitioning to the Community" POF and "Individuals At Risk for Avoidable Hospital or ED Utilization" POF. MCPs should already be monitoring these KPIs internally given the 2023 contractual requirement for assigned transitional care managers to make appropriate referrals for high-risk members. Also starting in 2024, DHCS will measure vision screening and dental care/coordination for children. Once the PHM Service is live, DHCS will monitor the percentage of eligible members enrolled in WIC and CalFresh. DHCS envisions evolving and updating the KPIs as appropriate as new policy requirements go into effect, such as providing transitional care services for all populations in 2024 or completing closed-loop referrals in 2025.

C. How DHCS will Monitor MCPs' PHM Programs and Conduct Enforcement When Needed

As stated above, DHCS will review the overall picture revealed by both KPIs and quality measures in each PHM monitoring domain and category, including patterns, trends, and outliers, to gain a holistic perspective on PHM Program implementation and operations at each MCP.

DHCS will review quality measures and KPIs in each PHM domain and monitoring category by examining the following:

- How MCPs performed compared to each other, with special attention to which plans are outliers (both above and below average performance);
- Whether MCPs made year-to-year improvements or maintained their performance if they were already high performers; and
- For quality measures only, whether MCPs performed below benchmarks such as Minimum Performance Levels (to the extent benchmarks exist). DHCS is not instituting benchmarks for KPIs at this time.

If any concerns arise in any PHM monitoring category, DHCS will engage in the following activities to drive improvement in MCPs' PHM programs:

- Meeting with MCPs to learn more and ask questions about their PHM Program, such as:
    - How does your PHM program support this monitoring category? What specific program initiatives address improvements in the category?
    - What changes have you made to your PHM program in the last year?
    - What internal monitoring do you have in place to manage your PHM program performance?
    - What challenges does your MCP face in addressing member's health in this category?
    - How is your PHM program addressing equity within this category?
- Requesting additional policies and procedures, or more granular data, including member-level data, if appropriate
- Via the technical assistance mechanisms already provided to MCPs by the Quality and Health Equity Transformation team to improve program implementation, operations, effectiveness, or outcomes. The Quality and Health Equity Transformation Branch staff will provide guidance throughout the year.

Existing quality and performance improvement enforcement requirements associated with MCAS measure performance will not change; PHM monitoring will be distinct, and in alignment with, these current requirements, as described above.

DHCS will also meet with high-performing outliers to understand and share best practices among MCPs in various PHM domains to support scaling and spread of promising practices.

Over time, if MCPs do not meet the PHM program requirements and achieve successful PHM outcomes, DHCS may impose Corrective Action Plans (inclusive of Quality Improvement Assessment and Strategic Plan), sanctions, and/or liquidated damages, as set out in the MCP contract, for MCPs' failure to comply with the PHM program requirements, the MCP contract, and/or applicable state and federal laws.[74]

For questions and additional information, please email PHMSection@dhcs.ca.gov.

D. Illustrative Example of DHCS Review of PHM Monitoring Category/Populations

Table 4 provides an example of which quality measures and KPIs DHCS will review to monitor how a MCP is performing on primary care engagement/appropriate utilization and how it is implementing its PHM program for children and youth.

Table 4. Illustrative Example of PHM Monitoring for BPHM – Primary Care Engagement/Appropriate Utilization and for Children and Youth

PHM Monitoring Category	KPIs	Quality Measures
BPHM: Primary Care Engagement/ Appropriate Utilization	• Percentage of members who had more ED visits than primary care visits within a 12-month period • Percentage of members who had at least one primary care visit within a 12-month period • Percentage of members with no ambulatory or preventive visit within a 12-month period	• Ambulatory Care: ED Visits • Adults' Access to Preventive/Ambulatory Health Services • Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits • Well-Child Visits in the First 30 Months of Life - 15 to 30 Months – Two or More Well-Child Visits • Child and Adolescent Well-Care Visits • CAHPS: Getting Needed Care • CAHPS: Getting Care Quickly
Children and Youth Population[75]	• Percentage of members under 21 eligible for CCM who are successfully enrolled in the CCM program • Percentage of members who had more ED visits than	• Depression Screening and Follow-Up for Adolescents • Depression Remission or Response for Adolescents • Well-Child Visits in the First 30 Months of Life-0 to 15 Months-Six or More Well-Child Visits • Well-Child Visits in the First 30 Months of Life-15 to 30

[74] Welfare and Institutions Code, § 14197.7

[75] These KPIs and quality measures are not additional measures; they are categorized in "Table 2. PHM Monitoring Quality Measures" and "Table 3. PHM Monitoring KPIs" above but are included here for a population-level analysis.

PHM Monitoring Category	KPIs	Quality Measures
	primary care visits in within a 12-month period • Percentage of members enrolled in all ECM Children and Youth POFs • Percentage of members enrolled in ECM "Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness" Children and Youth POFs • Percentage of members enrolled in ECM "Children and Youth At Risk for Avoidable Hospital or ED Utilization" POF • Percentage of members enrolled in ECM "Children and Youth with Serious Mental Health and/or SUD Needs" POF • Percentage of members enrolled in ECM "Children and Youth Transitioning from Incarceration" POF • Percentage of members enrolled in ECM "Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition" POF • Percentage of members enrolled in ECM "Children and Youth Involved in Child Welfare" POF	Months-Two or More Well-Child Visits • Child and Adolescent Well-Care Visits • Developmental Screening for the First Three Years of Life • Lead Screening for Children • Childhood Immunization Status: Combination 10 • Immunizations for Adolescents: Combination 2 • Topical Fluoride for Children • Ambulatory Care: Emergency Department (ED) Visits • Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase • Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase • CAHPS: Getting Needed Care (Child) • CAHPS: Getting Care Quickly (Child)

IV: *(Updated October 2023)* Implementation Timeline

The most recent PHM Program implementation timeline is outlined below. It includes the timeline for anticipated DHCS policy/guidance, MCP deliverable due dates, and general PHM Program go-live dates. For more information about key milestones and go-live dates for all CalAIM initiatives, please refer to the DHCS CalAIM Timelines webpage.

Quarter	DHCS Policy/Guidance	MCP Deliverables	Program Go-Live Dates
2023			

Q1	▪ **January 1:**
	  ▪ Elimination of IHEBA/SHA and Replacement of Individual Health Assessment with Individual Health Appointment
	  ▪ APLs 17-012 and 17-013 were superseded by APL 22-024.
	▪ **Q2:** Publish DHCS Monitoring Approach for Implementation of the PHM Program
			▪ **January 1: PHM Program Goes Live statewide with the following requirements, to the extent not already met:**
			  ▪ NCQA PHM accreditation or show equivalent
			  ▪ Good-faith effort to use DHCS-listed data sources to perform RSS
			  ▪ Wellness/prevention as required by NCQA
			  ▪ Initiatives to improve pregnancy outcomes
			  ▪ CCM as defined by NCQA
			  ▪ TCS requirements
			▪ **January 1: ECM goes live in all counties for LTC Populations of Focus**

Quarter	DHCS Policy/Guidance	MCP Deliverables	Program Go-Live Dates
Q3		▪ **May: PHM Policies and Procedures due for new plans** to align with requirements in APL 22-024[76]	
Q3	▪ **August:** APL 19-011 is superseded by APL 23-021 on new PNA/PHM Strategy deliverable requirements, which is accompanied by updates to the PHM Policy Guide with near time guidance on the PNA and PHM Strategy deliverable.	▪ **August:** MCPs to submit first set of data on KPIs for PHM monitoring	▪ **July 1: ECM goes live in all counties for Children and Youth Populations of Focus**
Q4:	▪ **October:** Updates to the Policy Guide with modified guidance on TCS policy and specific guidance on screening and assessments under the 2024 MCP Transition.	▪ **October: PHM Strategy Deliverable due** for current plans under revised requirements. Annual submission thereafter.	

[76] To align with requirements in APL 22-024, PHM Policies and Procedures are required to cover NCQA PHM accreditation or equivalent; readiness to use diverse data sources to guide RSS; approach to screening and assessment within revised 2023 requirements; approach to assessing for care management within revised 2023 requirements; and approach to BPHM, CCM, and TCS.

Quarter	DHCS Policy/Guidance	MCP Deliverables	Program Go-Live Dates
	▪ **December:** Updates to the Policy Guide with more detailed guidance on the modified PNA.		
2024			
Q1	▪ **January 1: New MCP Contract Goes Live**		▪ **January 1: ECM goes live in all counties for Birth Equity Population of Focus**
Q2			
Q3		▪ **October: PHM Strategy Deliverable due** for the first time for new plans and annually thereafter	
2025			
Q1-Q4	▪ CQS Bold Goals must be met	▪ The first modified PNA under the new approach per updated DHCS requirements and guideline	
2026			
Q1-Q4		▪ MCPs must obtain NCQA Health Plan Accreditation and NCQA Health Equity Accreditation	

Appendix 1: Key Terminology

1. **Admission, discharge, and transfer (ADT) feed** is a standardized, real-time data feed sourced from a health facility, such as a hospital, that includes members' demographic and healthcare encounter data at time of admission, discharge, and/or transfer from the facility.
2. **Assessment** is a process or set of questions for defining the nature of a risk factor or problem, determining the overall needs or health goals and priorities, and developing specific treatment recommendations for addressing the risk factor or problem. Health assessments can vary in length and scope.
3. **Basic Population Health Management (BPHM)** is an approach to care that ensures that needed programs and services are made available to each member, regardless of their risk tier, at the right time and in the right setting. BPHM includes federal requirements for care coordination (as defined in 42 C.F.R. § 438.208).
4. **Care manager** is an individual identified as a single point of contact responsible for the provision of care management services for a member.
5. **Care Management Plan (CMP)** is a written plan that is developed with input from the member and/or their family member(s), guardian, authorized representative, caregiver, and/or other authorized support person(s), as appropriate, to assess strengths, risks, needs, goals, and preferences, and make recommendations for service needs.
6. **Complex Care Management (CCM)** is an approach to care management that meets differing needs of high-and rising-risk members, including both longer-term chronic care coordination and interventions for episodic, temporary needs. Medi-Cal Managed care plans (MCPs) must provide CCM in accordance with all National Committee for Quality Assurance (NCQA) CCM requirements.
7. **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** is a federal entitlement that states are required to provide to all children under age 21 enrolled in Medicaid. This includes any Medicaid-coverable service in any amount that is medically necessary, regardless of whether the service is covered in the state plan.[77]
8. **Enhanced Care Management (ECM)** is a whole-person, interdisciplinary approach to care that addresses the clinical and nonclinical needs of high-cost and/or high-need members who meet ECM Populations of Focus eligibility criteria through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.
9. **Health Information Form (HIF)/Member Evaluation Tool (MET)** is a screening tool that is required to be completed within 90 days of MCP enrollment for new members. It fulfills the federal initial screening requirement.[78]
10. **Health Risk Assessment (HRA)** is an assessment required for Seniors and Persons with Disabilities. Effective January 1, 2023, HRA assessment requirements

[77] EPSDT in Medicaid. Medicaid and CHIP Payment and Access Commission. https://www.macpac.gov/subtopic/epsdt-in-medicaid/. DHCS specific requirements on EPSDT is outlined in APL 23-010.

[78] 42 CFR 438.208(b)(3)-(4)

for Seniors and Persons with Disabilities are simplified, while specific member protections are kept in place.

11. **Initial Health Appointment (IHA),** previously called Initial Health Assessment, now refers to appointment(s) required to be completed within 120 days of MCP enrollment for new members and must include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases.[79]
12. **Long-Term Care (LTC)** includes specialized rehabilitative services and care provided in a Skilled Nursing Facility, subacute facility, pediatric subacute facility, or Intermediate Care Facilities (ICFs).[80]
13. **Long-Term Services & Supports (LTSS**) includes services and supports designed to allow a member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both LTC and HCBS and includes carved-in and carved-out services. [81]
14. **Risk stratification and segmentation (RSS)** is the process of separating member populations into different risk groups and/or meaningful subsets using information collected through population assessments and other data sources. RSS results in the categorization of members with care needs at all levels and intensities.
15. **Risk tiering** is the assigning of members to standard risk tiers (i.e., high, medium-rising, or low), with the goal of determining appropriate care management programs or specific services.
16. **Population Health Management (PHM)** is a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.
17. **The Population Health Management (PHM) Service** collects and links Medi-Cal beneficiary information from disparate sources and performs risk stratification and segmentation (RSS) and tiering functions, conducts analytics and reporting, identifies gaps in care, performs other population health functions, and allows for multiparty data access and use in accordance with state and federal law and policy.
18. **Population Health Management Strategy (PHM Strategy)** is a comprehensive plan of action for addressing member needs across the continuum of care, based on Population Needs Assessment (PNA) results, data-driven risk stratification, predictive analysis, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions. Each MCP would be required to include, at a minimum, a description of how it will:

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[79] These required IHA elements are specified in 22 C.C.R. § 53851(b)(1).
[80] 2024 Re-Procurement. Exhibit A, Attachment I, Definitions and Acronyms
[81] 2024 Re-Procurement. Exhibit A, Attachment I, Definitions and Acronyms

- Keep all members healthy by focusing on wellness and prevention services;
- Identify and manage care and services for members with high and rising risk;
- Ensure effective transition planning across delivery systems or settings, through care coordination and other means, to minimize patient risk and ensure appropriate clinical outcomes for the member; and
- Identify and mitigate member access, experience, and clinical outcome disparities by race, ethnicity, and language to advance health equity.

19. **Screening** is a brief process or questionnaire for examining the possible presence of a particular risk factor or problem to determine whether a more in-depth assessment is needed in a specific area of concern.
20. **Social drivers of health (SDOH)** are 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 factors.
21. **Transitional care services (TCS)** are services provided to all members transferring from one institutional care setting or level of care to another institution or lower level of care (including home settings).
22. **Wellness and prevention programs** are programs that aim to prevent disease, disability, and other conditions; prolong life; promote physical and mental health and efficiency; and improve overall quality of life and well-being.

Appendix 2: Upcoming Updates to All Plan Letters (APLs)

Topic Within PHM Framework	Existing APLs	Upcoming Updates and Timing
PNA and PHM Strategy	**APL 23-021 "Population Needs Assessment and PHM Strategy"**	• Supersedes 19-011.
HRA/Risk Stratification/Care Management Plans	**APL 22-024 "Population Health Management Policy Guide"**	• Supersedes APL 17-013 and APL 17-012.
Initial Health Appointment(s) and IHEBA/SHA	**APL 22-030 "Initial Health Appointment"**	• Supersedes PL 08-003, 13-001, and APL 13-017
	APL 16-014 "Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries"	• This APL will be superseded to decouple requirements from outdated IHEBA/SHA requirement sometime in the future.
	APL 18-004 "Immunization Requirements"	• No changes.
	APL 20-004 "Emergency Guidance for Medi-Cal Managed Care Plans in Response to COVID-19"	• No changes.

Appendix 3: Standardized Long-Term Services and Supports (LTSS) Referral Questions

These standardized LTSS referral questions from APL 17-013 will continue to be required for MCPs or their delegates to use to assess members who may need LTSS. The questions are organized in the following two tiers, and MCPs must take a holistic view of questions in both tiers and identify members in need of follow-up assessment:

- Tier 1 contains questions directly related to LTSS eligibility criteria and should trigger a follow-up assessment to determine if the beneficiary is eligible for LTSS services.
- Tier 2 contains questions that identify contributory risk factors, which would put a beneficiary at higher risk for needing LTSS services when combined with risk factors identified in Tier 1.

The headings in italics are not part of the questions but provide the intent of the questions.

Tier 1 LTSS Questions:

Activities of Daily Living Functional Limitations/Instrumental Activities of Daily Living Limitations/Functional Supports (Functional Capacity Risk Factor)

Question 1: Do you need help with any of these actions? (Yes/No to each individual action)

a) Taking a bath or shower
b) Going up stairs
c) Eating
d) Getting dressed
e) Brushing teeth, brushing hair, shaving
f) Making meals or cooking
g) Getting out of a bed or a chair
h) Shopping and getting food
i) Using the toilet
j) Walking
k) Washing dishes or clothes
l) Writing checks or keeping track of money
m) Getting a ride to the doctor or to see your friends
n) Doing house- or yardwork
o) Going out to visit family or friends
p) Using the phone
q) Keeping track of appointments

If yes, are you getting all the help you need with these actions?

Housing Environment/Functional Supports (Social Determinants Risk Factor)

Question 2: Can you live safely and move easily around in your home? (Yes/No) If no, does the place where you live have: (Yes/No to each individual item)

a) Good lighting
b) Good heating
c) Good cooling
d) Rails for any stairs or ramps
e) Hot water
f) Indoor toilet
g) A door to the outside that locks
h) Stairs to get into your home or stairs inside your home
i) Elevator
j) Space to use a wheelchair
k) Clear ways to exit your home

Low Health Literacy (Social Determinants Risk Factor)

Question 3: “I would like to ask you about how you think you are managing your health conditions”

a) Do you need help taking your medicines? (Yes/No)
b) Do you need help filling out health forms? (Yes/No)
c) Do you need help answering questions during a doctor’s visit? (Yes/No)

Caregiver Stress (Social Determinants Risk Factor)

Question 4: Do you have family members or others willing and able to help you when you need it? (Yes/No)

Question 5: Do you ever think your caregiver has a hard time giving you all the help you need? (Yes/No)

Abuse and Neglect (Social Determinants Risk Factor)

Question 6a: Are you afraid of anyone, or is anyone hurting you? (Yes/No)

Question 6b: Is anyone using your money without your okay? (Yes/No)

Cognitive Impairment (Functional Capacity, Medical Conditions, Behavioral Health Condition Risk Factor)

Question 7: Have you had any changes in thinking, remembering, or making decisions? (Yes/No)

Tier 2 LTSS Questions:

Fall Risk (Functional Capacity Risk Factor)

Question 8a: Have you fallen in the last month? (Yes/No)

Question 8b: Are you afraid of falling? (Yes/No)

Financial Insecurity or Poverty (Social Determinants Risk Factor)
Question 9: Do you sometimes run out of money to pay for food, rent, bills, and medicine? (Yes/No)

Isolation (Social Determinants Risk Factor)

Question 10: Over the past month (30 days), how many days have you felt lonely? (Check one)

- ☐ None – I never feel lonely
- ☐ Less than five days
- ☐ More than half the days (more than 15)
- ☐ Most days – I always feel lonely

Appendix 4: List of Quality Measures and Descriptions for PHM Monitoring Approach

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
NA (DSF-E)	NCQA	**Depression Screening and Follow-Up for Adolescents and Adults**	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. • Depression Screening. The percentage of members who were screened for clinical depression using a standardized instrument. • Follow-Up on Positive Screen. The percentage of members who received follow-up care within 30 days of a positive depression screen finding.
1392 (W30-6+)	NCQA	**Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits**	Assesses children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life.
1392 (W30-2+)	NCQA	**Well-Child Visits in the First 30 Months of Life - 15 to 30 Months – Two or More Well-Child Visits**	Assesses children who turned 30 months old during the measurement year and had at least two well-child visits with a primary care physician in the last 15 months.
1516 (WCV)	NCQA	**Child and Adolescent Well-Care Visits**	Assesses children 3–21years of age who received one or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.
1448 (DEV)	OHSU	**Developmental Screening for the First Three Years of Life**	For members 1-3 years of age, percentage of children screened for risk of developmental, behavioral, and social delays

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
			using a standardized screening tool in the 12 months preceding or on their first, second or third birthday.
NA (LSC)	NCQA	**Lead Screening for Children**	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.
0038 (CIS-10)	NCQA	**Childhood Immunization Status: Combination 10**	The percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.
1407 (IMA-2)	NCQA	**Immunizations for Adolescents: Combination 2**	Assesses adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine and the complete human papillomavirus vaccine series by their 13th birthday.
2528 (TFL-CH)	DQA	**Topical Fluoride for Children**	Percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications as: (1) dental or oral health services, (2) dental services, and (3) oral health services within the measurement year.
NA (PND-E)	NCQA	**Prenatal Depression Screening and Follow Up**	The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
			follow-up care. Two rates are reported. • **Depression Screening:** The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument. • **Follow-Up on Positive Screen:** The percentage of deliveries in which members received follow-up care within 30 days of screening positive for depression.
NA (PDS-E)	NCQA	**Postpartum Depression Screening and Follow Up**	The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. Two rates are reported. • **Depression Screening:** The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the prenatal period. • **Follow-Up on Positive Screen:** The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.
0034 (COL-E)	NCQA	**Colorectal Cancer Screening**	Assesses adults 50–75 who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, computed tomography

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
			colonography every 5 years, stool DNA test every 3 years.
0033 (CHL)	NCQA	**Chlamydia Screening in Women**	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
NA (BCS-E)	NCQA	**Breast Cancer Screening**	Assesses women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years.
0032 (CCS)	NCQA	**Cervical Cancer Screening**	Assesses women who were screened for cervical cancer using any of the following criteria: • Women 21–64 years of age who had cervical cytology performed within the last 3 years. • Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.
NA (AMB-ED)	NCQA	**Ambulatory Care: Emergency Department (ED) Visits**	Assesses ED utilization, which tracks the number of ED visits. ED visits is defined as: each visit to an ED is counted once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following: • An ED visit (ED Value Set).

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
			• A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set).
NA (AAP)	NCQA	**Adults' Access to Preventive/Ambulatory Health Services**	The percentage of members 20 years and older who had an ambulatory or preventive care visit.
NA (DRR)	NCQA	**Depression Remission or Response for Adolescents and Adults**	The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4–8 months of the elevated score. • Follow-Up PHQ-9. The percentage of members who have a follow-up PHQ-9 score documented within 4–8 months after the initial elevated PHQ-9 score. • Depression Remission. The percentage of members who achieved remission within 4–8 months after the initial elevated PHQ-9 score. • Depression Response. The percentage of members who showed response within 4–8 months after the initial elevated **PHQ-9 score.**
1800 (AMR)	NCQA	**Asthma Medication Ratio**	Assesses adults and children 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
0059 (HBD)	NCQA	**Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (>9%)**	Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: HbA1c poor control (>9.0%).
0018 (CBP)	NCQA	**Controlling High Blood Pressure**	Assesses adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).
0105 (AMM-Acute)	NCQA	**Antidepressant Medication Management: Acute Phase Treatment**	Assesses adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications. *Effective Acute Phase Treatment:* Adults who remained on an antidepressant medication for at least 84 days (12 weeks).
0105 (AMM-Cont)	NCQA	**Antidepressant Medication Management: Continuation Phase Treatment**	Assesses adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications. *Effective Continuation Phase Treatment:* Adults who remained on an antidepressant medication for at least 180 days (6 months).
0108 (ADD-Init)	NCQA	**Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase**	*Initiation Phase:* Assesses children between 6 and 12 years of age who were diagnosed with ADHD and had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication.
0108 (ADD-C&M)	NCQA	**Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase**	*Continuation and Maintenance Phase:* Assesses children between 6 and 12 years of age who had a prescription for ADHD medication and remained on the medication for at least 210 days

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
			and had at least two follow-up visits with a practitioner in the 9 months after the Initiation Phase.
NA (POD)	NCQA	**Pharmacotherapy for Opioid Use Disorder**	Assesses the percentage of opioid use disorder (OUD) pharmacotherapy treatment events among members age 16 and older that continue for at least 180 days (6 months).
3489 (FUM)	NCQA	**Follow-Up after ED Visit for Mental Illness - 30 days**	Assesses emergency department (ED) visits for adults and children 6 years of age and older with a diagnosis of mental illness or intentional self-harm and who received a follow-up visit for mental illness within 30 days.
3488 (FUA)	NCQA	**Follow-Up after ED Visit for Substance Use - 30 day**	Assesses emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. • ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
1768 (PCR)	NCQA	**Plan All-Cause Readmissions**	Assesses the rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge among commercial (18 to 64), Medicaid (18 to 64) and Medicare (18 and older) health plan members. As well as reporting observed rates, NCQA also specifies that plans report a predicted probability of readmission to account for the prior and current health of the member, among other factors. A separate readmission rate for hospital stays discharged to a

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
			skilled nursing facility among members aged 65 and older is reported for Medicare plans. The observed rate and predicted probability is used to calculate a calibrated observed-to-expected ratio that assesses whether plans had more, the same or less readmissions than expected, while accounting for incremental improvements across all plans over time. The observed-to-expected ratio is multiplied by the readmission rate across all health plans to produce a risk-standardized rate which allows for national comparison.
NA (PPR)	CMS	**Potentially Preventable 30-day Post-Discharge Readmission**	Assesses readmissions during a 30-day period after discharge from the post-acute care provider (LTC reporting only)
1517 (PPC-Pst)	NCQA	**Prenatal and Postpartum Care: Postpartum Care**	*Postpartum Care.* The percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery.
1517 (PPC-Pre)	NCQA	**Prenatal and Postpartum Care: Timeliness of Prenatal Care**	*Timeliness of Prenatal Care.* The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
NA (NTSV CB)	The Joint Commission (TJC)	**Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate**	Identifies the proportion of live babies born at or beyond 37.0 weeks gestation to women in their first pregnancy, that are singleton (no twins or beyond) and in the vertex presentation (no breech or transverse positions), via cesarean birth
0006	Agency for Healthcare	**CAHPS: Getting Needed Care (Adult and Child)**	The survey asked enrollees how often it was easy for them to get appointments with specialists and

NQF# / Measure Acronym	Steward	Quality Measures	Descriptions (Please Refer to NCQA for Detailed Technical Specifications)
	Research and Quality		get the care, tests, or treatment they needed through their health plan.
0006	Agency for Healthcare Research and Quality	**CAHPS: Getting Care Quickly (Adult and Child)**	The survey asked enrollees how often they got care as soon as needed when sick or injured and got non-urgent appointments as soon as needed.

(Updated August 2023) Appendix 5: List of KPIs and Technical Specifications for PHM Monitoring Approach

KPIs to be reported starting in August 2023	PHM Program Area	Definitions
Percentage of members who had more ED visits than primary care visits within a 12-month period	BPHM - Primary Care Engagement/ Appropriate Utilization	**Numerator:** The number of members who have more ED visits than primary care visits within a 12-month period. **Denominator:** The total number of enrolled members in the MCP.
Percentage of members who had at least one primary care visit within a 12-month period	BPHM - Primary Care Engagement/ Appropriate Utilization	**Numerator:** The number of members who had at least one PCP visit within a 12-month period. **Denominator:** The total number of enrolled members in the MCP.
Percentage of members with no ambulatory or preventive visit within a 12-month period	BPHM - Primary Care Engagement/ Appropriate Utilization	**Numerator:** The number of members who no ambulatory or preventive visit within a 12-month period. **Denominator:** The total number of enrolled members in the MCP.
Percentage of members who received CHW benefit	BPHM - CHW Integration	**Numerator:** The number of unique members who had at least one CHW benefit encounter during the reporting period. **Denominator:** The total number of enrolled members in the MCP during the reporting period.
Percentage of members eligible for CCM who are successfully enrolled in the CCM program	CCM	**Rate A Numerator:** The number of members who are enrolled in CCM for 1 or more days during the Measurement Period. **Rate A Denominator:** The number of members eligible for CCM for 1 or more days during the Measurement Period. **Rate B Numerator:** The number of members who are enrolled in CCM for 1 or more days during the Measurement Period, excluding those members who were enrolled in CCM for 1 or more days during the previous Measurement Period. **Rate B Denominator:** The number of members eligible for CCM for 1 or more days

KPIs to be reported starting in August 2023	PHM Program Area	Definitions
		during the Measurement Period, excluding those members who were enrolled in CCM for 1 or more days during the previous Measurement Period.
Percentage of members enrolled in ECM	ECM	**Numerator:** The number of members who are enrolled in ECM. **Denominator:** The total number of enrolled members in the MCP.
Percentage of members enrolled in ECM "Individuals Experiencing Homelessness" Population of Focus (POF)	ECM	**Numerator:** The number of members who are enrolled in ECM "Individuals Experiencing Homelessness" POF. **Denominator:** The total number of enrolled members in the MCP.
Percentage of members enrolled in ECM "Individuals At Risk for Avoidable Hospital or ED Utilization" POF	ECM	**Numerator:** The number of members who are enrolled in ECM "Individuals At Risk for Avoidable Hospital or ED Utilization" POF. **Denominator:** The total number of enrolled members in the MCP.
Percentage of members enrolled in ECM "Individuals with Serious Mental Health and/or Substance Use Disorder (SUD) Needs" POF	ECM	**Numerator:** The number of members who are enrolled in ECM "Individuals with Serious Mental Health and/or Substance Use Disorder (SUD)" POF. **Denominator:** The total number of enrolled members in the MCP.
Percentage of members enrolled in ECM "Individuals Transitioning from Incarceration" POF	ECM	**Numerator:** The number of members who are enrolled in ECM "Individuals Transitioning from Incarceration" POF. **Denominator:** The total number of enrolled members in the MCP.
Percentage of members enrolled in ECM "Adults Living in the Community and At Risk for LTC Institutionalization" POF	ECM	**Numerator:** The number of members who are enrolled in ECM "Adults Living in the Community and At Risk for LTC Institutionalization" POF. **Denominator:** The total number of enrolled members in the MCP.

KPIs to be reported starting in August 2023	PHM Program Area	Definitions
Percentage of members enrolled in ECM "Adult Nursing Facility Residents Transitioning to the Community" POF	ECM	**Numerator:** The number of members who are enrolled in ECM "Adult Nursing Facility Residents Transitioning to the Community" POF. **Denominator:** The total number of enrolled members in the MCP.
Percentage of members enrolled in all ECM Children and Youth POFs	ECM	**Numerator:** The number of members who are enrolled in all ECM "Children and Youth" POFs. **Denominator:** The total number of members under 21 enrolled in the MCP.
Percentage of members enrolled in all ECM "Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness" POF	ECM	**Numerator:** The number of members who are enrolled in all ECM "Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness" Children and Youth POFs. **Denominator:** The total number of members under 21 enrolled in the MCP.
Percentage of members enrolled in ECM "Children and Youth At Risk for Avoidable Hospital or ED Utilization" POF	ECM	**Numerator:** The number of members who are enrolled in ECM "Children and Youth At Risk for Avoidable Hospital or ED Utilization" POF. **Denominator:** The total number of members under 21 enrolled in the MCP.
Percentage of members enrolled in ECM "Children and Youth with Serious Mental Health and/or SUD Needs" POF	ECM	**Numerator:** The number of members who are enrolled in ECM "Children and Youth with Serious Mental Health and/or SUD Needs" POF. **Denominator:** The total number of members under 21 enrolled in the MCP.
Percentage of members enrolled in ECM "Children and Youth Transitioning from Incarceration" POF	ECM	**Numerator:** The number of members who are enrolled in ECM "Children and Youth Transitioning from Incarceration" POF. **Denominator:** The total number of members under 21 enrolled in the MCP.
Percentage of members enrolled in ECM "Children and Youth Enrolled in California Children's	ECM	**Numerator:** The number of members who are enrolled in ECM "Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition" POF.

KPIs to be reported starting in August 2023	PHM Program Area	Definitions
Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition" POF		**Denominator:** The total number of members under 21 enrolled in the MCP.
Percentage of members enrolled in ECM "Children and Youth Involved in Child Welfare" POF	ECM	**Numerator:** The number of members who are enrolled in ECM "Children and Youth Involved in Child Welfare" POF. **Denominator:** The total number of members under 21 enrolled in the MCP.
Percentage of contracted acute care facilities from which MCPs receive ADT notifications	Transitional Care Services	**Numerator:** The number of general contracted acute facilities from which MCPs receive ADT feeds. **Denominator:** The total number of contracted general acute facilities.
Percentage of contracted skilled nursing facilities from which MCPs receive ADT notifications	Transitional Care Services	**Numerator:** The number of contracted skilled nursing facilities from which MCPs receive ADT feeds. **Denominator:** The total number of contracted skilled nursing facilities. ***Skilled Nursing Facilities exclude intermediate care facilities/developmentally disabled (ICF/DD)***
Percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post discharge	Transitional Care Services	**Numerator:** The number of transitions for high-risk members during the Intake Period followed by at least one interaction with their assigned care manager within 7 days of post discharge. **Denominator:** The number of transitions for high-risk members during the Intake Period.
Percentage of acute hospital stay discharges who had follow-up ambulatory visits within 7 days post hospital discharge	Transitional Care Services	**Numerator:** The number of acute care hospital live discharges among enrolled MCP members during the measurement period with an ambulatory visit within 7 days post hospital discharge. **Denominator:** The number of live discharges from acute care hospitals among enrolled MCP members during the measurement period.

DHCS will leverage data that MCPs already report on where possible for PHM monitoring. Below are the KPIs DHCS will leverage from IPP and ECM QMIR:

IPP:

- Percentage of members who received CHW benefit
- Percentage of contracted acute care facilities from which MCPs receive ADT notifications
- Percentage of contracted skilled nursing facilities from which MCPs receive ADT notifications
- Percentage of acute hospital stay discharges which had follow-up ambulatory visits within 7 days post hospital discharge.

ECM:

- Percentage of members enrolled in ECM
- Percentage of members enrolled in ECM “Individuals Experiencing Homelessness" Population of Focus (POF)
- Percentage of members enrolled in ECM "Individuals At Risk for Avoidable Hospital or ED Utilization" POF
- Percentage of members enrolled in ECM "Individuals with Serious Mental Health and/or Substance Use Disorder (SUD) Needs" POF
- Percentage of members enrolled in ECM “Individuals Transitioning from Incarceration" POF
- Percentage of members enrolled in ECM "Adults Living in the Community and At Risk for LTC Institutionalization" POF
- Percentage of members enrolled in ECM "Adult Nursing Facility Residents Transitioning to the Community" POF
- Percentage of members enrolled in ECM “Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness” POF
- Percentage of members enrolled in ECM “Children and Youth At Risk for Avoidable Hospital or ED Utilization” POF
- Percentage of members enrolled in ECM “Children and Youth with Serious Mental Health and/or SUD Needs” POF
- Percentage of members enrolled in ECM “Children and Youth Transitioning from Incarceration” POF
- Percentage of members enrolled in ECM “Children and Youth Enrolled in California Children’s Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition” POF
- Percentage of members enrolled in ECM “Children and Youth Involved in Child Welfare” POF
- Percentage of members enrolled in all ECM Children and Youth POFs

MCPs are required to submit data for the five new KPIs following the technical specifications outlined below.

PHM KPI 1: Members Utilizing Emergency Department Care More than Primary Care

Description

The number and percentage of members who had more emergency department (ED) visits than primary care visits within a 12-month period.

Definitions

Measurement Period	The 12-month period beginning 15 months prior to the time of reporting. For instance, if submitting on August 15, 2023, the measurement period would start on May 15, 2022, and end on May 14, 2023.
ED Visit	An ED visit as defined by the NCQA ED Value Set.
Primary Care Provider	Primary care is defined by DHCS as care usually rendered in ambulatory settings by Primary Care Providers (PCP) and emphasizes the Member's preventive health needs, general health needs, and chronic disease management. A PCP is a Provider responsible for supervising, coordinating, and providing initial and primary care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN).
Primary Care Visit	A primary care visit is defined as an ambulatory or preventive visit delivered by a Primary Care Provider, as identified in the methodology below. For the purposes of this KPI, a primary care visit does not have to be with a member's assigned PCP.

Eligible Population

Ages	Report total rate and age stratifications as required for all PHM KPI submissions. The total rate is calculated by considering members of all ages.
Continuous Enrollment	There are no continuous enrollment criteria for this measure. The count of members for the measure should be a point-in-time count at the time of submission.
Required Exclusion	Members in hospice or using hospice services anytime during the Measurement Period.

Administrative Specification

Denominator	The total cumulative and unduplicated number of enrolled members in the Managed Care Plan during the Measurement Period. To exclude members in hospice or using hospice services during the measurement period, use the following NCQA value sets: • Hospice Encounter Value Set

<table>
<tr><td></td><td>

- Hospice Intervention Value Set

</td></tr>
<tr><td>Numerator</td><td>
The number of enrolled members who have had more ED visits than Primary Care Visits within a 12-month period.

For each member, determine:

ED Visits:
Use the NCQA ED Value Set to calculate the number of ED visits in the Measurement Period for each member.

Primary Care Visits
Use the following steps to calculate the number of Primary Care Visits in Measurement Period for each member.

Step 1: Use the following NCQA value sets to identify ambulatory or preventive care visits in the last 12 months for each member:

Ambulatory Visits Value Set.
Other Ambulatory Visits Value Set.
Telephone Visits Value Set.
Online Assessments Value Set.
Well-Care Value Set

Step 2: Of these visits, identify those visits conducted by primary care providers based on National Provider Identifier (NPI) information. Exclude all visits that do not meet either of these NPI attributions for primary care providers:

The NPI of the rendering or billing provider of the visit is flagged as a primary care provider on at least one of the monthly 274 Provider Files that the Managed Care Plan submits to DHCS during the Measurement Period.

OR

The NPI of the rendering or billing provider of the visit is represented in the National Plan and Provider Enumeration System (NPPES) as being a primary care provider, as defined by the following provider types by the first four digits of their taxonomy codes in the claim or encounter data for the visit:

<table>
<tr><th>Provider Type</th><th>First Digits of Taxonomy</th></tr>
<tr><td>General practitioner</td><td>207D</td></tr>
<tr><td>Internist</td><td>207R</td></tr>
<tr><td>Pediatrician</td><td>2080</td></tr>
<tr><td>Family practitioner</td><td>207Q</td></tr>
<tr><td>Non-physician medical practitioner</td><td>363L, 363A</td></tr>
</table>
</td></tr>
</table>

Obstetrician-gynecologist (OB-GYN)	207V

Step 3: Of remaining visits, identify visits delivered in a primary care setting. is a site of usual delivery of primary care, as defined the taxonomy code for Service Setting within the visit. Include only visits that have the following Service Settings:

Service Setting	First Digits of Taxonomy
Community Health	261QC1500
Corporate Health	261QC1800
Health Service	261QH0100
Migrant Health	261QM1000
Primary Care	261QP2300
Public Health, State or Local	261QP0905
Student Health	261QS1000
Critical Access Hospital	261QC0050
Medical Specialty	261QM2500
Multi-Specialty	261Q1300X
Clinic/Center Not Otherwise Specified	261Q00000
Federally Qualified Health Center	261QF0400
Rural Health	261QR1300

Step 4: Sum the identified primary care visits, representing the total number of Primary Care Visits during the measurement period for each member.

Step 5: identify the number of members for whom the number of ED Visits is greater than the number of Primary Care Visits during the Measurement Period.

Data Elements for Calculation and Reporting

Report at the plan-level both the count and percentage of total enrolled members, including by the required stratifications below, for whom the number of ED visits is greater than the number of Primary Care Visits within a 12-month period.

Stratify data by:

(1) Age:

a. Birth-5 years, 6-11 years, 12-20 years, 21-64 year, 65 years and older
Note: For age-based stratification, use the member's age at the end of the measurement period. For example, if someone turns 12 years old before the end of the reporting period, they would be stratified in the "12-20 years" group. If someone turns 12 years old after the end of the reporting period, they should be stratified in the "6-11 years" group.

(2) Race: Report only one of the following 9 categories for race
    a. White
    b. Black or African American
    c. American Indian and Alaska Native
    d. Asian
    e. Native Hawaiian and Other Pacific Islander
    f. Some Other Race
    g. Two or More Races
    h. Asked but No Answer
    i. Unknown
(3) Ethnicity: Report only one of the following 4 categories for ethnicity per member
    a. Hispanic/Latino
    b. Not Hispanic/Latino
    c. Asked but No Answer
    d. Unknown
(4) Language: Report on the member's primary spoken language (one language per member)
    a. English
    b. Spanish
    c. Most prevalent language spoken by Managed Care Plan members other than English or Spanish (Managed Care Plan to Identify)
    d. Other languages

For the Total Rate and each reporting stratum, specify both the absolute number of members in the numerator and denominator and the percentage calculated by dividing the numerator by the denominator.

Notes; Alignment with Other DHCS Reporting Initiatives

This KPI aligns with value sets used in other measures required for reporting to DHCS as referenced above, especially the NCQA Value Sets:

- ED Value Set
- Ambulatory Visits Value Set
- Other Ambulatory Visits Value Set
- Telephone Visits Value Set
- Online Assessments Value Set
- Well-Care Value Set

DHCS will calculate this measure independently to compare with Managed Care Plan-reported rates. If there are discrepancies between Managed Care Plan-calculated and DHCS-calculated rates, DHCS will work with the MCP to obtain member-level data, meet with MCPs to learn more and ask questions about their PHM Program, or request to review additional policies and procedures.

PHM KPI 2: Members Engaged in Primary Care

Description

The number and percentage of members who had at least one primary care visit within a 12-month period.

Definitions

Measurement Period	The 12-month period beginning 15 months prior to the time of reporting. For instance, if submitting on August 15, 2023, the measurement period would start on May 15, 2022, and end on May 14, 2023.
Primary Care Visit	An ambulatory or preventive visit delivered by a general practitioner in a general care setting, as defined by health care service categorization codes and place of service codes.
Primary Care Provider	Primary care is defined by DHCS as care usually rendered in ambulatory settings by Primary Care Providers (PCP), and mid-level practitioners, and emphasizes the Member's general health needs as opposed to Specialists focusing on specific needs. A PCP is a Provider responsible for supervising, coordinating, and providing initial and primary care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN).
Primary Care Visit	A primary care visit is defined as an ambulatory of preventive visit delivered by a Primary Care Provider, as identified in the methodology below. For the purposes of this KPI, a primary care visit does not have to be with a member's assigned PCP.

Eligible Population

Continuous Enrollment	There are no continuous enrollment criteria for this measure. The count of members for the measure should be a point-in-time count at the time of submission.
Ages	Report total rate and age stratifications as required for all PHM KPI submissions. The total rate is calculated by considering members of all ages.
Required Exclusion	Members in hospice or using hospice services anytime during the Measurement Period.

Administrative Specification

Denominator	The total cumulative and unduplicated number of enrolled members in the Managed Care Plan during the Measurement Period.

<table>
<tr><td></td><td>To exclude members in hospice or using hospice services during the measurement period, use the following NCQA value sets:
Hospice Encounter Value Set
Hospice Intervention Value Set</td></tr>
<tr><td>Numerator</td><td>The number of members who had one or more Primary Care Visit(s) within a 12-month period.

Use the following steps to calculate the number of Primary Care Visits in Measurement Period for each member.

Step 1: Use the following NCQA value sets to identify ambulatory or preventive care visits in the last 12 months for each member:
Ambulatory Visits Value Set.
Other Ambulatory Visits Value Set.
Telephone Visits Value Set.
Online Assessments Value Set.
Well-Care Value Set
Step 2: Of these visits, identify those visits conducted by primary care providers based on National Provider Identifier (NPI) information. Exclude all visits that do not meet either of these NPI attributions for primary care providers:
The NPI of the rendering or billing provider of the visit is flagged as a primary care provider on at least one of the monthly 274 Provider Files that the Managed Care Plan submits to DHCS during the Measurement Period.
OR
The NPI of the rendering or billing provider of the visit is represented in the National Plan and Provider Enumeration System (NPPES) as being a primary care provider, as defined by the following provider types by the first four digits of their taxonomy codes in the claim or encounter data for the visit:
<table>
<tr><th>Provider Type</th><th>First Digits of Taxonomy</th></tr>
<tr><td>General practitioner</td><td>207D</td></tr>
<tr><td>Internist</td><td>207R</td></tr>
<tr><td>Pediatrician</td><td>2080</td></tr>
<tr><td>Family practitioner</td><td>207Q</td></tr>
<tr><td>Non-physician medical practitioner</td><td>363L, 363A</td></tr>
<tr><td>Obstetrician-gynecologist (OB-GYN)</td><td>207V</td></tr>
</table>
</td></tr>
</table>

	Step 3: Of remaining visits, identify visits delivered in a primary care setting. is a site of usual delivery of primary care, as defined the taxonomy code for Service Setting within the visit. Include only visits that have the following Service Settings:

Service Setting	First Digits of Taxonomy
Community Health	261QC1500
Corporate Health	261QC1800
Health Service	261QH0100
Migrant Health	261QM1000
Primary Care	261QP2300
Public Health, State or Local	261QP0905
Student Health	261QS1000
Critical Access Hospital	261QC0050
Medical Specialty	261QM2500
Multi-Specialty	261Q1300X
Clinic/Center Not Otherwise Specified	261Q00000
Federally Qualified Health Center	261QF0400
Rural Health	261QR1300

Data Elements for Reporting

Report at the plan-level both the count and percentage of total enrolled members, including by the required stratifications below, who had at least one visit with a primary care provider within a 12-month period.

Stratify data by:

(1) Age:

a. Birth-5 years, 6-11 years, 12-20 years, 21-64 year, 65 years and older
Note: For age-based stratification, use the member's age at the end of the measurement period. For example, if someone turns 12 years old before the end of the reporting period, they would be stratified in the "12-20 years" group. If someone turns 12 years old after the end of the reporting period, they should be stratified in the "6-11 years" group.

(2) Race: Report only one of the following 9 categories for race

a. White
b. Black or African American
c. American Indian and Alaska Native
d. Asian
e. Native Hawaiian and Other Pacific Islander
f. Some Other Race
g. Two or More Races
h. Asked but No Answer

i. Unknown

(3) Ethnicity: Report only one of the following 4 categories for ethnicity per member
   a. Hispanic/Latino
   b. Not Hispanic/Latino
   c. Asked but No Answer
   d. Unknown

(4) Language: Report on the member's primary spoken language (one language per member)
   a. English
   b. Spanish
   c. Most prevalent language spoken by Managed Care Plan members other than English or Spanish (Managed Care Plan to Identify)
   d. Other languages

For the Total Rate and each reporting stratum, specify both the absolute number of members in the numerator and denominator and the percentage calculated by dividing the numerator by the denominator.

Notes; Alignment with Other DHCS Reporting Initiatives

This KPI aligns with value sets used in other measures required for reporting to DHCS as referenced above, especially the NCQA Value Sets:

- ED Value Set
- Ambulatory Visits Value Set.
- Other Ambulatory Visits Value Set.
- Telephone Visits Value Set.
- Online Assessments Value Set.
- Well-Care Value Set

DHCS will calculate this measure independently to compare with Managed Care Plan-reported rates. If there are discrepancies between Managed Care Plan-calculated and DHCS-calculated rates, DHCS will work with the MCP to obtain member-level data, meet with MCPs to learn more and ask questions about their PHM Program, or request to review additional policies and procedures.

PHM KPI 3: Members Not Engaged in Ambulatory Care

Description

The percentage of members with no ambulatory or preventive visit within a 12-month period.

Definitions

Measurement Period	The 12-month period beginning 15 months prior to the time of reporting. For instance, if submitting on August 15, 2023, the measurement period would start on May 15, 2022, and end on May 14, 2023.

Eligible Population

Ages	Report total rate and age stratifications as required for all PHM KPI submissions. The total rate is calculated by considering members of all ages.
Continuous Enrollment	There are no continuous enrollment criteria for this measure. The count of members for the measure should be a point-in-time count at the time of submission.
Required Exclusion	Members in hospice or using hospice services anytime during the Measurement Period.

Administrative Specification

Denominator	The total cumulative and unduplicated number of enrolled members in the Managed Care Plan during the measurement period. To exclude members in hospice or using hospice services during the measurement period, use the following NCQA value sets: • Hospice Encounter Value Set • Hospice Intervention Value Set
Numerator	The number of members who had no (zero) ambulatory or preventive visits within a 12-month period. Use the following value sets to identify ambulatory or preventive care visits within a 12-month period for each member: • Ambulatory Visits Value Set. • Other Ambulatory Visits Value Set. • Telephone Visits Value Set. • Online Assessments Value Set. • Well-Care Value Set

Data Elements for Reporting

Report at the plan-level both the count of and percentage of total enrolled members, including by the required stratifications below, who had no (zero) ambulatory or preventive visits within a 12-month period.

Stratify data by:

(1) Age:
   a. Birth-5 years, 6-11 years, 12-20 years, 21-64 year, 65 years and older
      Note: For age-based stratification, use the member's age at the end of the measurement period. For example, if someone turns 12 years old before the end of the reporting period, they would be stratified in the "12-20 years" group. If someone turns 12 years old after the end of the reporting period, they should be stratified in the "6-11 years" group.

(2) Race: Report only one of the following 9 categories for race
   a. White
   b. Black or African American
   c. American Indian and Alaska Native
   d. Asian
   e. Native Hawaiian and Other Pacific Islander
   f. Some Other Race
   g. Two or More Races
   h. Asked but No Answer
   i. Unknown

(3) Ethnicity: Report only one of the following 4 categories for ethnicity per member
   a. Hispanic/Latino
   b. Not Hispanic/Latino
   c. Asked but No Answer
   d. Unknown

(4) Language: Report on the member's primary spoken language (one language per member)
   a. English
   b. Spanish
   c. Most prevalent language spoken by Managed Care Plan members other than English or Spanish (Managed Care Plan to Identify)
   d. Other languages

For the Total Rate and each reporting stratum, specify both the absolute number of members in the numerator and denominator and the percentage calculated by dividing the numerator by the denominator.

Notes; Alignment with Other DHCS Reporting Initiatives

This KPI is aligns with value sets used in other measures required for reporting to DHCS as referenced above, especially the NCQA Value Sets:

- Ambulatory Visits Value Set
- Other Ambulatory Visits Value Set
- Telephone Visits Value Set
- Online Assessments Value Set
- Well-Care Value Set

DHCS will calculate this measure independently to compare with Managed Care Plan-reported rates. If there are discrepancies between Managed Care Plan-calculated and DHCS-calculated rates, DHCS will work with the MCP to obtain member-level data, meet with MCPs to learn more and ask questions about their PHM Program, or request to review additional policies and procedures.

PHM KPI 4: Percentage of Eligible Members enrolled in Complex Care Management

Description

The number and percentage of members eligible for Complex Care Management (CCM) who are successfully enrolled in the CCM program.

This measure has two rates:

- **KPI 4 Rate A:** CCM enrollment among all eligible members
- **KPI 4 Rate B:** CCM enrollment among eligible members who were not already enrolled during the previous reporting period.
    - Note: MCPs are not required to report KPI 4 Rate B for the first submission on August 15, 2023.

Rate B looks at the subset of members that who were not enrolled in CCM in the last reporting period and identifies new enrollment into CCM.

Definitions

Measurement Period	The 90-day period starting 135 days prior to the submission date and ending 45 days preceding the submission date. For instance, if submitting on August 15, 2023, the measurement period would start on April 2, 2023, and end on June 30, 2023.
Complex Care Management Program	Complex Care Management in this measure equates to "Complex Case Management," as defined by NCQA and described by Plans in their submissions to the Department of Health Care Services.
Eligible for Complex Care Management	Eligibility criteria for Complex Care Management varies by Managed Care Plan. Each Managed Care Plan should use its most current criteria when analyzing this measure.

Eligible Population

Ages	Report total rate and age stratifications as required for all PHM KPI submissions. The total rate is calculated by considering members of all ages.
Continuous Enrollment	There are no continuous enrollment criteria for this measure. The count of members for the measure should be a point-in-time count at the time of submission.
Required Exclusion	Members in hospice or using hospice services anytime during the Measurement Period.

Administrative Specifications

Rate A Denominator	The total cumulative and unduplicated number of members eligible for CCM for 1 or more days during the Measurement Period.

	To exclude members in hospice or using hospice services during the measurement period, use the following NCQA value sets: • Hospice Encounter Value Set • Hospice Intervention Value Set
Rate A Numerator	The number of members who are enrolled in CCM for 1 or more days during the Measurement Period.

Rate B identifies enrollment in CCM among members who are eligible but were not already receiving CCM services during the previous reporting period. This rate assesses new uptake of CCM services.

Rate B Denominator	The total cumulative and unduplicated number of members eligible for CCM for 1 or more days during the Measurement Period, excluding those members who were enrolled in CCM for 1 or more days during the previous Measurement Period. To exclude members in hospice or using hospice services during the measurement period, use the following NCQA value sets: • Hospice Encounter Value Set • Hospice Intervention Value Set
Rate B Numerator	The number of members who are enrolled in CCM for 1 or more days during the Measurement Period, excluding those members who were enrolled in CCM for 1 or more days during the previous Measurement Period.

Data Elements for Reporting

Report at the plan-level both the count and percentage of members eligible for CCM who are successfully enrolled in the CCM program.

Stratify data by:

(1) Age:

a. Birth-5 years, 6-11 years, 12-20 years, 21-64 year, 65 years and older
Note: For age-based stratification, use the member's age at the end of the measurement period. For example, if someone turns 12 years old before the end of the reporting period, they would be stratified in the "12-20 years" group. If someone turns 12 years old after the end of the reporting period, they should be stratified in the "6-11 years" group.

(2) Race: Report only one of the following 9 categories for race

a. White
b. Black or African American
c. American Indian and Alaska Native
d. Asian
e. Native Hawaiian and Other Pacific Islander
f. Some Other Race
g. Two or More Races
h. Asked but No Answer

i. Unknown

(3) Ethnicity: Report only one of the following 4 categories for ethnicity per member
   a. Hispanic/Latino
   b. Not Hispanic/Latino
   c. Asked but No Answer
   d. Unknown

(4) Language: Report on the member's primary spoken language (one language per member)
   a. English
   b. Spanish
   c. Most prevalent language spoken by Managed Care Plan members other than English or Spanish (Managed Care Plan to Identify)
   d. Other languages

For the Total Rate and each reporting stratum, specify both the absolute number of members in the numerator and denominator and the percentage calculated by dividing the numerator by the denominator.

Notes; Alignment with Other DHCS Reporting Initiatives

DHCS requires current Managed Care Plans to submit Policies and Procedures on CCM Models of care to align with requirements in APL 22-024. Because CCM eligibility criteria vary by Managed Care Plan, DHCS will compare submitted rates with each Managed Care Plan's eligibility criteria for context. Because CCM is not captured in claims and encounter data, DHCS reserves the right to ask Plans to submit member-level CCM enrollment in the future.

PHM KPI 5: Care Management for High-Risk Members after Discharge

Description

The number and percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post discharge.

This measure's denominator includes events experienced by members who both:

- Are identified as being high-risk, as defined below
- Meet the definition for acute and non-acute care stays, as defined below

Definitions

Intake Period	The 12-month period starting 15 months and 7 days prior to the time of reporting. For instance, if submitting on August 15, 2023, the intake period would start on May 8, 2022, and end on May 7, 2023.
Measurement Period	The 12-month and 7-day period beginning 1 day after the beginning of the Intake Period and ending 7 days after the end of the Intake Period. For instance, if submitting on August 15, 2023, the measurement period would start on May 9, 2022, and end on May 14, 2023.
Transitions	Defined as the end of **Inpatient and observation stays and Nonacute inpatient stays.** • **Inpatient and observation stay** is defined by combining the NCQA Inpatient Stay Value Set and NCQA Observation Stay Value Set • **Nonacute inpatient stay** is defined by the NCQA Nonacute Inpatient Stay Value Set
Assigned care manager	Defined as "the single point of contact responsible 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." MCPs can assign members to a care manager either by using its own staff or contracting with other contracted entities (e.g., hospitals, ACOs, PCPs, etc.)."
Day post discharge	Day is defined as calendar days, irrespective of whether the day falls on a weekend or holiday. A post-discharge occurs after the date of discharge. This definition excludes both interactions that occur while the member is still in an inpatient setting and interactions that occur on the same calendar day of discharge.
High-risk	Defined below as a subset of "Populations Required to Receive an Assessment and Re-assessment." Members with these risk factors should receive transitional care services starting January 1, 2023. These high-risk groups include: • Members receiving long-term services and supports (LTSS)

	• Members eligible for Complex Care Management • Members eligible for Enhanced Care Management. This criterion includes all active populations of focus at the time of measurement. • Members enrolled in the California Children's Services (CCS) program • Members who are pregnant • Members assessed to be high-risk by the Plan's risk stratification and segmentation approaches prior to PHM Service RSST functionality is live.
Interaction	An interaction is a synchronous interaction involves the use of in-person, telephonic, or audio-visual communication in real time. This definition excludes asynchronous communication such as leaving voicemails or portal-based communications.
Long Term Supports and Services	Long Term Supports and Services (LTSS) are defined as services and supports designed to allow a member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both Long Term Care (LTC) and Home and Community Based Services (HCBS) as well as carved-in and carved-out services. A subset of these services are operationalized for this measure.

Eligible Population	
Ages	Report total rate and age stratifications as required for all PHM KPI submissions. The total rate is calculated by considering members of all ages.
Continuous Enrollment	There are no continuous enrollment criteria for this measure.
Required Exclusion	Members in hospice or using hospice services anytime during the Measurement Period. Members enrolled in MMPs or any other D-SNPs.

Administrative Specification	
Denominator	The number of transitions for high-risk members during the Intake Period To exclude members in hospice or using hospice services during the measurement period, use the following NCQA value sets: • Hospice Encounter Value Set • Hospice Intervention Value Set
Numerator	The number of transitions for high-risk members during the Intake Period followed by at least one interaction with their assigned care manager within 7 days post discharge.

	If members have multiple transitions of care involving discharge from an acute care setting, count these episodes separately.

To identify denominator-qualifying events, identify admissions in both acute inpatient and non-acute inpatient admissions during the Intake Period using the following NCQA Value Sets:

- Inpatient Stay Value Set
- Observation Stay Value Set
- Nonacute Inpatient Stay Value Set

These value sets include admissions in acute inpatient, skilled nursing, and residential treatment settings. Among these events, exclude any events not experienced by members who meet the following operationalized definition of "High Risk"":

High Risk Group	Data Source and Process
Eligible for Complex Care Management	Internal Managed Care Plan Data and Identification Process. For guidance on Aid-Code-based methods on identifying youth currently or formerly engaged with the foster care system, see the Enhanced Care Management Policy Guide, pg. 97.
Eligible for Enhanced Care Management	
Assessed to be high-risk by the Plan's risk stratification and segmentation approaches	
Enrolled in the California Children's Services (CCS) program	
Members who are pregnant	Use the NCQA Pregnancy Value Set to identify members who are pregnant during care episode of the discharge event or through any other care episode in the 30 days prior to the discharge event.
Receiving Long Term Supportive Services	Internal Managed Care Plan Data and Identification Processes. LTSS is defined above, and Plans should specifically include the following groups: • Those who received Home Health (HH) services in the 30 days prior to the admission date of the discharge event, as identified by Vendor Code (44) • Those who received In-Home Supportive Services (IHSS) in the 30 days prior to the admission date of the

	discharge event (data as available to Plan) • Those who had one or more long-term care (LTC) stay in the 30 days prior to the admission date of the discharge event

For numerator compliance, evaluate each denominator-qualifying event using the following steps:

Step 1: Identify the date of discharge of the denominator-qualifying event experienced by a member in a high-risk group.

Step 2: Count all synchronous post-discharge interactions between an Assigned Care Manager and the member experiencing the denominator-qualifying event occurring during the period starting on the calendar day after discharge and ending seven calendar days after discharge.

For this measure, the calendar date of discharge can be considered Day 0. Numerator-compliant interactions should occur on Days 1 to 7 after the discharge event.

Step 3: Identify numerator compliance by excluding all denominator-qualifying events for which the number of contacts calculated in Step 2 is zero.

Treat each denominator-qualifying event separately, meaning that each individual member can have multiple transitions of care during the measurement period.

Data Elements for Reporting

Report at the plan-level both the count of and percentage of transitions experienced by high-risk members followed by an assigned care manager visit within 7 days after discharge.

Stratify data by:

(1) Age:

a. Birth-5 years, 6-11 years, 12-20 years, 21-64 year, 65 years and older
Note: For age-based stratification, use the member's age at the end of the measurement period. For example, if someone turns 12 years old before the end of the reporting period, they would be stratified in the "12-20 years" group. If someone turns 12 years old after the end of the reporting period, they should be stratified in the "6-11 years" group.

(2) Race: Report only one of the following 9 categories for race

a. White
b. Black or African American
c. American Indian and Alaska Native
d. Asian
e. Native Hawaiian and Other Pacific Islander

f. Some Other Race
g. Two or More Races
h. Asked but No Answer
i. Unknown

(3) Ethnicity: Report only one of the following 4 categories for ethnicity per member
a. Hispanic/Latino
b. Not Hispanic/Latino
c. Asked but No Answer
d. Unknown

(4) Language: Report on the member's primary spoken language (one language per member)
a. English
b. Spanish
c. Most prevalent language spoken by Managed Care Plan members other than English or Spanish (Managed Care Plan to Identify)
d. Other languages

For the Total Rate and each reporting stratum, specify both the absolute number of members in the numerator and denominator and the percentage calculated by dividing the numerator by the denominator.

Notes; Alignment with Other DHCS Reporting Initiatives

This measure presumes utilization of ADT feeds or other methods to identify member discharges. Care manager contact information should be obtained from Plans' internal care management information systems.

Policy:	GG.1357p
Title:	**Population Health Management Transitional Care Services (TCS)**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/*
Effective Date:	01/01/2023
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines CalOptima Health's Transitional Care Services (TCS) and describes the process by which CalOptima Health, Health Networks, and providers engage Members across all settings and delivery systems, ensuring Members are supported from discharge planning until they have been successfully connected to all needed services and supports.
Care transitions are defined as a Member transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or long-term care (LTC) settings. This includes critical TCS tasks, such as ensuring that medication reconciliation is completed upon discharge by the discharging facility, and that every member has follow-up care by a Provider, including another medication reconciliation completed post-discharge to reduce medication discrepancies, errors, and adverse drug events that are common and can lead to poor outcomes in transitions.

II. POLICY

A. CalOptima Health shall establish and maintain a Population Health Management (PHM) Program in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Program and CalOptima Health Policy GG.1667: CalAIM Population Health Management Program.

1. 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.

2. The PHM Program includes Basic Population Health Management (BPHM), Care Management, Complex Care Management (CCM), Enhanced Care Management (ECM), and TCS.

   a. TCS shall be provided for High-Risk Members, along with Members enrolled in Case Management or ECM through a single point of contact responsible for providing Longitudinal Support and ensuring all required services are complete which may be the

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TCS Assigned Care Manager; the ECM Lead Care Manager (LCM) for members enrolled in ECM; or, the CCM Care Manager for members enrolled in Case Management.

b. TCS shall be provided for non-High-Risk Members.

c. TCS shall be provided to Members in ICF/DD Homes, in accordance with CalOptima Health Policy GG.1802: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an IC/DD, ICF/DD-H, and ICF/DD-N.

B. Under the PHM Program and in line with CalAIM initiatives, CalOptima Health shall fully implement TCS for all Members by January 1, 2024.

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

D. If a Member has an existing CCM Care Manager or ECM LCM, CalOptima Health or a Health Network is responsible for notifying the CCM Care Manager or ECM LCM of the ADT.

E. CalOptima Health and Health Networks shall take an incremental approach to the provision of TCS services and continually strengthen the process to ensure Member-centered care. TCS is being rolled out in collaboration with CalOptima Health and Health Network contracted Facility partners to ensure alignment and avoid duplication.

III. PROCEDURE

A. Transitional Care Services (TCS) for High-Risk Members.

1. CalOptima Health and Health Networks shall provide TCS 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.

a. As part of the TCS process, CalOptima Health and Health Networks shall identify a TCS Assigned Care Manager as a single point of contact for TCS High-Risk Members to ensure completion of TCS in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up after discharge.

b. The provision of TCS is provided through the TCS Assigned Care Manager; the ECM LCM for members enrolled in ECM; or, the CCM Care Manager for members enrolled in Case Management.

2. CalOptima Health and Health Networks shall communicate with the Facility where the Member is admitted so the TCS Assigned Care Manager, ECM LCM, or CCM Care Manager can participate in discharge planning and support access to available services.

3. CalOptima Health and Health Networks shall offer Members direct assistance of the TCS Assigned Care Manager, ECM LCM, or CCM Care Manager; however, Members may choose to have limited contact or decline contact with the Care Manager, in accordance with the DHCS CalAIM: Population Health Management (PHM) Policy Guide.

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a. In these cases, at a minimum, the TCS Assigned Care Manager, ECM LCM, or CCM Care Manager must act as a liaison coordinating care among the discharging facility, the Primary Care Practitioner (PCP), and CalOptima Health or Health Networks.

4. CalOptima Health shall ensure the TCS Assigned Care Managers, ECM LCM, or CCM Care Manager are notified within twenty-four (24) hours of admission, transfer, or discharge through an Admission, Discharge, and Transfer (ADT) Feed notification or within twenty-four (24) hours of being made aware of an admission, transfer, or discharge when an ADT Feed is not available.

5. CalOptima Health or a Health Network and the TCS Assigned Care Manager, ECM LCM, or CCM Care Manager is responsible for coordinating and verifying that Members receive all appropriate TCS, regardless of setting.

6. CalOptima Health and Health Networks shall ensure Prior Authorizations required for a Member's discharge are processed in a timely manner, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

7. CalOptima Health or Health Networks and the TCS Assigned Care Managers, ECM LCM, or CCM Care Manager shall collaborate with the facility on the discharge risk assessment and planning document for High-Risk Members

8. Beginning January 1, 2024, the Facility must share the discharge planning documents with the TCS Assigned Care Manager which includes the ECM LCM or the CCM Care Manager, Members, Member's parents, legal guardians, or Authorized Representatives when being discharged from a hospital, institution, or facility; and must include:

   a. Pre-admission status:

      i. Living arrangements;

      ii. Physical and mental function;

      iii. Substance Use Disorder needs;

      iv. Social Support;

      v. DME uses; and

      vi. Other services received prior to admission.

   b. Pre-discharge factors:

      i. Medical condition;

      ii. Physical and Mental function;

      iii. Financial resources; and

      iv. Social supports at the time of discharge.

   c. The hospital, institution or facility to which the Member was admitted.

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d. Specific recommendations by the hospital, institution, or facility:

i. Specific agency or home recommended based on Member needs and preferences;

ii. Specific services needed after discharge;

iii. Specific description of the type of placement preferred by Member;

iv. Specific description of type of placement agreed to by Member ;

v. Specific description of agency or Member's return to home agreed to by the Member; and

vi. Recommended pre-discharge counseling.

e. Summary to be included in the Member's Medical Record:

i. Nature and outcome of participation of Member, Member's parents, legal guardians, or authorized representatives in the Discharge Planning process;

ii. Anticipated problems in implementing post discharge plans; and

iii. Further action contemplated by the hospital, institution, or facility.

f. Information regarding:

i. Available care, services, and supports in the Member's community once discharged; and

ii. Scheduled outpatient appointment or follow-up with the Member.

g. The discharge facility shall leverage the assessment to identify and refer Members who may benefit from High-Risk TCS services. This process must include referrals to CalOptima or the Health Network for:

i. Any Member who has a specialty mental health need or substance use disorder;

ii. Any Member who is eligible for an ECM Population of Focus; and

iii. Any Member whom the clinical team feels is High-Risk and may benefit from more intensive transitional care support upon discharge.

9. Hospital Discharged Members High Risk

a. CalOptima Health and Health Networks will outreach, and triage Members based on risk and care coordination needs.

i. CalOptima Health enhanced data identification processes are utilized to identify High-Risk Members.

ii. High-Risk identified Member data is shared on a monthly basis with the Health Networks.

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b. The TCS Assigned Care Manager, ECM LCM or CCM Care Manager shall ensure needed post-discharge services are provided and referrals are made, follow-ups are scheduled and completed, including, but not limited to:

i. Assisting with making follow up Provider appointments, to occur within seven (7) days post-discharge;

ii. Connecting to the PCP (if PCP has changed); and

iii. Arranging transportation, in accordance with CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical.

iv. Substance Use Disorder, (SUD) and mental health treatment initiation or continuation for those who have an identified SUD or Mental health condition;

v. Medication reconciliation, post discharge;

vi. Completion of referrals to social service organizations, and referrals to necessary at-home services (DME, home health, etc.);

vii. Connection to Community Supports as needed; and

viii. Members transitioning to or from nursing facilities.

10. End of TCS Services for High-Risk Members.

a. TCS shall 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, and extend at minimum for thirty (30) calendar days post-discharge.

b. Members with ongoing care coordination needs shall be assessed and referred for ECM or CCM services as appropriate.

c. CalOptima Health or a Health network will ensure Members with multiple care transitions within a thirty (30) day period have the same TCS Assigned Care Manager, ECM LCM, or CCM Care Manager assigned to support them through the transitions.

d. For a Member who does not respond to outreach attempts or did not attend scheduled follow-up ambulatory visits, CalOptima Health or a Health network must make reasonable effort to ensure engagement and follow-up ambulatory visits are completed which may include but not limited to use of Community Health Workers (CHWs)

e. If a second transition is within seven (7) calendar days of the first transition, then the TCS Assigned Care Manager, ECM LCM, or CCM Care Manager must ensure the follow up visit is completed within seven (7) calendar days post discharge after the last transition and continue to provide support for at least thirty (30) calendar days.

B. Transitional Care Services for non-High-Risk Members effective January 1, 2024

1. CalOptima Health or a Health Network shall ensure lower-risk Members have access to the following for at least thirty (30) calendar days from discharge:

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a. Have access to a dedicated TCS team;

b. Have access to a dedicated telephonic support services with a live team; and

c. Post-discharge Ambulatory follow up:

i. Encourage that Member completes follow up ambulatory visit with Provider within thirty (30) calendar days of discharge.

C. CalOptima Health and delegated Health Networks will use data including any information from admission, to identify newly qualified Members for outreach and enrollment into ECM, CCM, and/or Community Supports.

D. CalOptima Health shall ensure delegated Health Networks follow and coordinate services.

E. CalOptima Health is responsible for all TCS requirements for Members who are dually eligible for Medi-Cal and Medicare enrolled in Medicare FFS or MA Plans (except D-SNPS).

F. CalOptima Health and Health Networks shall conduct timely Prior Authorizations for Medi-Cal benefits where Medi-Cal is the primary payor in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals .

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

1. CalOptima Health and Health Networks will be responsible for providing TCS services for Members admitted when the Orange County Health Care Agency (OCHCA) Orange County Mental Health Plan (OCMHP) is not the primary payor.

H. 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).

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical
C. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Health Policy GG.1667: CalAIM Population Health Management Program
E. 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)
F. CalOptima Health Policy GG.1802: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an IC/DD, ICF/DD-H, and ICF/DD-N
G. CalOptima Health Policy GG.1803: Authorization Process, and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility – Adult/Pediatric

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H. CalOptima Health Policy GG.1804: Admission to, Continued Stay in, and Discharge from Out-of-Network Nursing Facility Level A (NF-A) and Level B (NF-B)
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) CalAIM: Population Health Management (PHM) Policy Guide, October 2023

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/15/2023	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	01/01/2023	GG.1357p	Population Health Management Transitional Care Services (TCS)	Medi-Cal

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IX. GLOSSARY

Term	Definition
Authorized Representative	A person designated by the Member or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Admission, Discharge, and Transfer (ADT) Feed	A standardized, real-time data feed sourced from a health facility, such as a hospital, that includes Members' demographic and healthcare encounter data at time of admission, discharge, and/or transfer from the facility.
Basic Population Health Management (BPHM)	An approach to care that ensures that needed programs and services are made available to each Member, regardless of their risk tier, at the right time and in the right setting. BPHM includes federal requirements for care coordination (as defined in 42 C.F.R. § 438.208).
Care Coordination	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.
Care Transitions	A Member transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and Skilled Nursing Facilities (SNFs) to home- or community-based settings, Community Supports placements (including sobering centers, recuperative care and short-term post hospitalization), post-acute care facilities, or Long-Term Care (LTC) settings.
Care Manager	An individual identified as a single point of contact responsible for the provision of care management services for a Member.
Case Management	A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.
Community Supports	Substitute services or settings to those required under the California Medicaid State Plan that CalOptima Health may select and offer to their Members pursuant to 42 CFR section 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.
Complex Case Management (CCM)	The systematic coordination and assessment of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management.
Department of Health Care Services (DHCS)	The single State Department responsible for 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.
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
Enhanced Care Management (ECM) Lead Care Manager	The Lead Care Manager (LCM) is a Member's designated care manager for ECM, who works for the ECM Provider organization and in the case of CalOptima Health Direct (COD) serving as the ECM Provider, the LCM could be on staff with CalOptima Health. The LCM operates as part of the Member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any Community Supports. To the extent a Member has other care managers or participates in other care management programs, the LCM will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services
Facility	Any premise that is: 1. Owned, leased, used or operated directly or indirectly by or for CalOptima Health for purposes related in the DHCS Medi-Cal Contract, or 2. Maintained by a Provider to provide services on behalf of CalOptima Health.
Health Equity	The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network

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Term	Definition

High-Risk Members	For purposes of this policy Members which include:
	• Those with Long-Term Services and Supports (LTSS) needs (as required by federal and state law and waiver).
	• Those entering Complex Care Management (CCM) (per NCQA).
	• Those entering Enhanced Care Management (ECM).
	• Children with Special Health Care Needs (CSHCN).
	• Pregnant individuals.
	• Seniors or Persons with Disabilities who meet the definition of "high risk" as established in existing APL requirements, namely:
	  ○ Members who have been authorized to receive:
	  ▪ In-Home Supportive Services (IHSS) greater than, or equal to, one-hundred and ninety-five (195) hours per month;
	  ▪ Community-Based Adult Services (CBAS), and/or
	  ▪ Multipurpose Senior Services Program (MSSP) Services.
	  ○ Members who:
	  ▪ Have been on oxygen within the past ninety (90) days;
	  ▪ Are residing in an acute hospital setting;
	  ▪ Have been hospitalized within the last ninety (90) days or have had three (3) or more hospitalizations within the past year;
	  ▪ Have had three (3) or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g., multiple prescriptions consistent with the diagnosis of chronic diseases);
	  ▪ Have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern (e.g., homelessness);
	  ▪ Have end-stage renal disease, Acquired Immunodeficiency Syndrome (AIDS), and/or a recent organ transplant;
	  ▪ Have cancer and are currently being treated;
	  ▪ Are pregnant;
	  ▪ Have been prescribed antipsychotic medication within the past ninety (90) days;
	  ▪ Have been prescribed fifteen (15) or more prescriptions in the past ninety (90) days;
	  ▪ Have a self-report of a deteriorating condition; and
	  ▪ Have other conditions as determined by the MCP, based on local resources.
	  ▪ Any member who has been served by county SMHS and/or DMC or DMC-ODS (if known) within the last 12 months, or any member who has been identified as having a specialty mental health need or substance use disorder by the MCP or discharging facility;
	  ▪ Any member transitioning to or from a SNF;
	  ▪ Any member that is identified as high risk by the discharging facility and thus is referred or recommended by the facility for high-risk TCS.

Longitudinal Support	A single relationship must span the whole transition.

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Term	Definition
Long Term Care (LTC)	Specialized rehabilitative services and care provided in a Skilled Nursing Facility, and subacute care services that lasts longer than the remainder of the month of admission plus one (1) month.
Medical Record	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
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.
Population Health Management	A whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses Member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.
Population of Focus	Subject to the phase-in requirements prescribed by DHCS and Member transition requirements for HHP and WPC, Members eligible to participate in ECM under the CalAIM initiative include the following, as defined by DHCS: 1. Adult Populations of Focus include the following: a. Individuals and families experiencing Homelessness; b. Adult high utilizers; c. Adults with Serious Mental Illness (SMI) and/or substance use disorders (SUD); d. Individuals transitioning from incarceration; e. Individuals who are at risk for institutionalization and are eligible for long-term care (LTC); f. Nursing facility residents who want to transition to the community; 2. Populations of Focus for Children and Youth include the following: a. Children (up to age 21) experiencing Homelessness; b. High utilizers; c. Serious Emotional Disturbance (SED) or identified to be a clinical high risk for psychosis or experiences a first episode of psychosis; d. Enrolled in California Children's Services (CCS) Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition; e. Involved in, or with a history of involvement in, child welfare (including foster care up to age 26); and f. Transitioning from incarceration.

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.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval of Medically Necessary Covered Services, including the amount, duration and scope of services, except in the case of an emergency.
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.
Skilled Nursing Facility (SNF)	As defined in Title 22 CCR Section 51121(a), any institution, place, building, or agency which is licensed as a SNF by the California Department of Public Health or is a distinct part or unit of a hospital, meets the standard specified in Section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home", "convalescent hospital", "nursing home," or "nursing facility."
Transitional Care Services (TCS)	Services provided to all Members transferring from one institutional care setting or level of care to another institution or lower level of care (including home settings).
Transitional Care Services (TCS) Assigned Care Manager	For purposes of this policy, defined as the single point of contact responsible 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.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken February 1, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Authorize Actions Related to Membership of the CalOptima Health Board of Directors' Finance and Audit Committee and Quality Assurance Committee

Contact

Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Actions

1. Establish the membership of the CalOptima Health Board of Directors' (Board) Finance and Audit Committee (FAC) and the Quality Assurance Committee (QAC) at no less than three seats for each committee; and
2. Authorize the Board Chair to increase the number of committee seats in accordance with the Board composition and expertise, if necessary.

Background/Discussion

One March 12, 1996, the Board established the Finance Committee and the QAC, each consisting of three Board members appointed by the CalOptima Health Board Chair.

The Finance Committee was charged with oversight responsibilities for all financial matters affecting CalOptima Health. In November 2009, the Board changed the Finance Committee title to the Board of Directors' FAC and expanded the scope of responsibilities to include audit oversight. At the April 1, 2021, meeting, the Board expanded the size of the FAC from three to four Board members.

The QAC is charged with oversight responsibilities related to the overall quality of CalOptima Health programs. At the October 3, 2019, meeting, the Board reduced the size of the QAC from four to three seats.

Management recommends the Board establish membership at no less than three seats for the FAC and QAC, respectively, and authorize the Board Chair to increase the number of committee seats depending on the Board's composition, expertise, and interest.

Fiscal Impact

There is no fiscal impact.

Rationale for Recommendation

The recommended actions will ensure that the FAC and QAC meet on a regular basis and make recommendations to the full Board on financial and quality-related issues while providing additional flexibility to the Board Chair to increase the committee membership, if necessary.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
None

/s/ Michael Hunn *01/25/2024*
Authorized Signature **Date**

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CalOptima Health Board Action Agenda Referral

Action to Be Taken February 1, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

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

Contacts

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

Recommended Action

The Member Advisory Committee (MAC) recommends the Board of Directors (Board) approve the MAC's appointment of Christine Tolbert as the MAC Chair for a term starting February 1, 2024, and ending September 5, 2024.

Background

The CalOptima Health Board established the MAC by resolution on February 14, 1995, to serve solely in an advisory capacity, providing input and recommendations concerning CalOptima Health programs. The MAC is comprised of 17 voting members, including one standing member from the Orange County Social Services Agency.

Pursuant to Resolution Nos. 95-0214 and 20-0806, the Board is responsible for appointing the MAC Chair every two years from among appointed MAC members. The Chair may serve a two-year term.

Discussion

On December 19, 2023, the Orange County Board of Supervisors appointed MAC Chair Maura Byron to the CalOptima Health Board of Director's Member Seat, leaving the MAC without a Chair. The MAC appointed Christine Tolbert, the current Vice Chair of the MAC, to step into the role of Chair through September 5, 2024 (subject to the Board's approval under this recommend action), at which time the MAC will appoint a Chair for a new two-year term and ask the Board to approve that appointment.

Because appointing Ms. Tolbert as the Chair will leave the Vice Chair role vacant (if the Board approves Ms. Tolbert's Chair appointment), the MAC will submit a Vice Chair candidate to fill the vacant role through September 5, 2024, for the Board's approval at the Board's March 2024 meeting.

MAC Chair Candidate

Christine Tolbert's current work for the State Council on Developmental Disabilities has allowed her to advocate for thousands of people dealing with an expansive number of medical and/or special needs conditions. She has helped transition people from the state hospital into the community, allowing them to access health care services through managed care. Ms. Tolbert is the current Persons with Special Needs Representative on the MAC, previously served as MAC Chair from 2020 through 2022, and is the current Vice-Chair of the MAC.

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Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
With the appointment of the current MAC Chair, Maura Byron, to the CalOptima Board's Member Seat, the MAC recommends that the Board approve the MAC's appointment of Christine Tolbert, the current Vice-Chair of the MAC, to fulfill the remaining term as the MAC Chair.

Concurrence
Member Advisory Committee
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
None

/s Michael Hunn *01/25/2024*
Authorized Signature **Date**

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

9. Approve Actions Related to Federal Advocacy Services

Contact

Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Actions

Authorize the release of a request for proposals (RFP) for federal advocacy services and approve an updated scope of work (SOW) to be released with the RFP, effective July 1, 2024.

Background

CalOptima Health retains representation in Washington, DC to assist with tracking, analysis, and advocacy regarding federal legislation, regulations, and appropriations. In addition, CalOptima Health's representatives develop and maintain relationships with members and staff of the United States Congress as well as federal departments and regulatory agencies, including but not limited to the Centers for Medicare and Medicaid Services.

On May 6, 2021, following CalOptima Health's standard procurement process, the CalOptima Health Board of Directors (Board) authorized the Chief Executive Officer to execute a contract with Potomac Partners DC LLC (PPDC) to provide federal advocacy services for an approximately three-year term from May 21, 2021, through June 30, 2024, with two one-year extension options each exercisable at CalOptima Health's sole discretion. The Board subsequently amended PPDC's contract on February 2, 2023, to set its current rate at $27,000 per month, with no more than $5,000 per year in out-of-the-ordinary expenses authorized in advance by CalOptima Health.

Discussion

Given the expiration of PPDC's current contract on June 30, 2024, and in light of CalOptima Health's evolving strategic and public policy priorities since the approval of the current SOW, staff recommends that the Board authorize the release of an RFP for federal advocacy services and approve a revised SOW to be released with the RFP. The contract with the selected advocacy services vendor will be effective July 1, 2024, upon the expiration of the current contract with PPDC. Among other updates, the proposed SOW includes additional directives regarding proactive and high-touch advocacy strategies, federal program monitoring, coalition building, and specific federal entities and officials to engage. Following completion of the RFP process, staff will return to the Board with a request to select an advocacy firm and authorize the execution of a new contract that includes the updated SOW.

Fiscal Impact

The recommended action has no fiscal impact. Management will include administrative expenses for federal advocacy services in the CalOptima Health Fiscal Year 2024-25 Operating Budget.

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Rationale for Recommendation

Federal advocacy efforts continue to be a priority for CalOptima Health given the level of activity on health care issues in Washington, DC. CalOptima Health anticipates that several important issues will require its focus, attention, involvement, and advocacy.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Proposed SOW for Federal Advocacy Services

/s/ Michael Hunn *01/25/2024*
Authorized Signature **Date**

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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, Federal & Local Government Affairs; and Director, Public Policy; and/or their designees 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, procedures, and reporting requirements of the Clerk of the United States House of Representatives, the Secretary of the United States Senate, and any other necessary entities for which registration and reporting 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 federal government of the United States of America, including but not limited to the following entities:
    - United States Senate:
        - Committee on Finance (including the relevant subcommittees thereof);
        - Committee on Health, Education, Labor and Pensions (including the relevant subcommittees thereof);
    - United States House of Representatives:
        - Committee on Ways and Means (including the relevant subcommittees thereof);
        - Committee on Energy and Commerce (including the relevant subcommittees thereof);
    - Executive Office of the President of the United States (EOP);
    - United States Department of Health and Human Services (HHS);
    - United States Centers for Medicare and Medicaid Services (CMS); and
    - Any other federal departments, agencies, boards, and commissions, when directed by CalOptima.

5. Prioritize the development of relationships with Members of Congress 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 Congressional 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 federal 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 Washington, DC. Meetings and briefings may include formal briefings, as well as informal social meetings, as appropriate.

8. Notify CalOptima of anticipated, introduced or amended federal 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 federal legislation;
    - Providing copies of legislation, committee analyses, and any other relevant analyses;
    - Providing information relative to Congressional 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 programs and funding opportunities that relate to CalOptima.

10. Advocate for CalOptima's programs, positions on legislation introduced in the United States Congress, and positions on administrative, budgetary, and regulatory proposals introduced by federal agencies and the EOP. 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 Members of Congress and their staff;
    - Identifying witnesses, preparing written testimony, and delivering verbal testimony as directed before committees of the United States Congress; and
    - Creating and leading necessary advocacy coalitions.

11. Proactively identify and engage in additional opportunities for CalOptima to influence federal legislative, regulatory, budgetary, and administrative proposals and policymaking processes for the benefit of CalOptima.

12. Maintain relationships with, and engage in partnership opportunities with, CalOptima's trade associations and other health care and non-health care associations and organizations to advance CalOptima's shared advocacy priorities.

13. Provide monthly, written reports which shall include federal legislative, regulatory, budgetary, and administrative updates, 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 Congress, Congressional staff, and appropriate federal departments, agencies, boards, commissions, and any staff thereof. The reports shall be delivered on a schedule as directed by CalOptima staff and may be included in the publicly available CalOptima Board agendas and/or otherwise provided to Board members. The frequency of written reports may be modified at any time.

14. Provide in-person and/or over-the-phone briefings, as directed by CalOptima staff, to the CalOptima Board and executive leadership.

15. Provide to CalOptima staff the copies of all written correspondence, testimony, and position papers given on behalf of CalOptima, as well as access to federal appropriations documents and any other relevant materials, as they become available.

CalOptima staff may prepare a formal annual review of CONTRACTOR's work product at the end of each calendar and/or 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.

CalOptima Health Board Action Agenda Referral

Action To Be Taken February 1, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

10. Approve Actions Related to State and Local Advocacy Services

Contact

Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Action

1. Ratify CalOptima Health's short-term contract with Clear Advocacy LLC (Clear Advocacy) for state and local advocacy services, effective December 19, 2023, through April 18, 2024.
2. Authorize the re-release of a Request for Proposals (RFP) for state and local advocacy services effective April 19, 2024.

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 state departments and regulatory agencies, including but not limited to the California Department of Health Care Services.

As part of CalOptima Health's standard procurement process, an RFP for state and local advocacy services was issued on June 28, 2023, and proposals were received from two advocacy firms. Subsequently, evaluations and interviews were conducted by a staff evaluation committee, which recommended Strategies 360, Inc. (Strategies 360). On September 7, 2023, the Board authorized the Chief Executive Officer to contract with Strategies 360 for a three-year and one-month period, effective October 1, 2023, through October 31, 2026, which aligned the contract schedule with the state legislative cycle and the Governor's signing and vetoing deadlines. The contract also included a one two-year extension option exercisable at CalOptima Health's sole discretion with Board approval.

On November 7, 2023, the Strategies 360 project manager (*i.e.*, primary lobbyist) assigned to CalOptima Health's account voluntarily separated employment from Strategies 360. On November 13, 2023, CalOptima Health issued a written notice of termination without cause to Strategies 360 in accordance with the terms of its contract, and Strategies 360 confirmed that its services had been halted effective November 7, 2023. Strategies 360 subsequently filed for Chapter 11 bankruptcy for reasons unrelated to its California operations or the performance of the project manager or other staff assigned to CalOptima Health's account.

Following separation from Strategies 360, CalOptima Health's assigned project manager joined the lobbying firm Clear Advocacy as a partner.

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Discussion

To ensure continuity in CalOptima Health's representation in Sacramento with its existing contracted primary lobbyist, the Chief Executive Officer executed a short-term four-month contract with Clear Advocacy and hereby requests its ratification by the Board. Effective December 19, 2023, through April 18, 2024, the executed contract includes the same statement of work (SOW) as the terminated contract with Strategies 360 but at a slightly reduced rate of $12,400 per month ($49,600 total), which includes direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, and materials. As part of standard practice, staff will monitor the performance of Clear Advocacy to ensure that the deliverables and components outlined in the contract and SOW are being achieved.

In addition, staff requests the Board's authorization to re-release the RFP for state and local advocacy services. Non-substantive updates may be incorporated into the SOW. 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 and local advocacy services, effective April 19, 2024, to coincide with the expiration of the current short-term contract with Clear Advocacy.

Fiscal Impact

Funding for the recommended action is included in the Government Affairs budget under the CalOptima Health Fiscal Year 2023-24 Operating Budget approved by the Board on June 1, 2023.

Rationale for Recommendation

State and local advocacy efforts continue to be a priority for CalOptima Health given the level of activity on health care issues in Sacramento and Orange County. CalOptima Health anticipates that several important issues will require its focus, attention, involvement, and advocacy.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Entities Covered by this Recommended Board Action
2. Clear Advocacy Contract No. 24-10520

/s/ Michael Hunn *01/25/2024*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Clear Advocacy LLC	1121 L Street, Suite 700	Sacramento	CA	95814

CONTRACT NO. 24-10520 ("**Contract**")
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA HEALTH ("**CalOptima**")
And
CLEAR ADVOCACY LLC
("**CONTRACTOR**")

This Contract is made and entered into as of the date last signed below ("**Effective Date**"), by and between the Orange County Health Authority, a public agency dba CalOptima Health ("**CalOptima**") and Clear Advocacy LLC, hereinafter referred to as "**CONTRACTOR.**" CalOptima and CONTRACTOR may be referred to herein collectively as the "**Parties**" or each individually as a "**Party.**"

RECITALS

A. CalOptima desires to retain a contractor to provide State Advocacy Services, as described in the Scope of Work in Exhibit A;

B. CONTRACTOR provides such services;

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

D. CONTRACTOR desires to perform these services for CalOptima; and

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

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. "**Contract Documents**" include the following documents in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and addenda. Any new terms and conditions attached to CONTRACTOR's best and final offer, Proposal, invoices, or request for payment shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All Contract Documents are incorporated into this Contract by this reference. Any changes to the Contract or the Contract Documents shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima in accordance with Section 10, of this Contract. In the event of any conflict of provisions among the Contract and/or Contract Documents, the provisions shall prevail in the above-referenced descending order of precedence.

2. Scope of Work.

   2.1 CONTRACTOR shall perform the work in accordance with (i) this Contract, including the Scope of Work in Exhibit A, (ii) the Contract Documents, (iii) the applicable standards and requirements of the Centers for Medicare and Medicaid Services ("**CMS**"), the California Department of Health Care Services ("**DHCS**"), and the California Department of Managed Health Care ("**DMHC**"), and (iv) all applicable laws.

3. Insurance.

   3.1 At CONTRACTOR's sole expense and prior to undertaking performance of services under this Contract and at all times during performance hereunder, CONTRACTOR shall maintain insurance policies and amounts set forth in Exhibit A, which shall be full-coverage insurance not subject to

self-insurance provisions, in accordance with applicable laws and industry standards. CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the Term.

3.2 Within five (5) days of the Effective Date and prior to commencing performance of any services or its receipt of any compensation under the Contract, CONTRACTOR shall furnish to CalOptima with additional insured endorsements broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR. CONTRACTOR's Certificates of Insurance shall additionally comply with the following:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR, including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies, as applicable, and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this Contract, the CONTRACTOR's insurance coverage shall be primary insurance with respect to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies, as applicable.

3.2.3 CONTRACTOR's insurance carrier agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the CONTRACTOR for CalOptima. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this Section 3.2 and Exhibit A. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If CONTRACTOR maintains higher limits than the minimums required in this Contract, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

3.2.9 Require the insurance carrier to provide thirty (30) days' prior written notice of cancellation to CalOptima.

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3 and Exhibit A, CalOptima may terminate this Contract upon written notice to CONTRACTOR. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

3.4 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth in this Contract.

3.6 "**Occurrence**" means any event or related exposure to conditions that result in bodily injury or property damage.

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR shall defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "**Indemnified Parties**") against any and all claims, losses, demands, damages, costs, expenses, or liability arising out CONTRACTOR's, or its officers, employees, subcontractors, agents, or representatives', breach of this Contract, negligence, recklessness, or intentional conduct, except to the extent any such loss was caused by the gross negligence, recklessness, or intentional misconduct of CalOptima. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions at its sole expense, which shall include all costs and fees, including attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding. CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except claims arising through the sole negligence or sole willful misconduct of CalOptima.

4.2 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

4.3 CONTRACTOR's indemnification and duty to defend obligations shall survive the expiration or earlier termination of this Contract until such time as any action against the Indemnified Parties for such a matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including those set forth under the California Government Claims Act (Cal. Gov. Code §900 *et seq.*).

4.4 In the event of any conflict between this Section 4 and the indemnification provisions set forth elsewhere in the Contract, including any business associate agreement ("**BAA**") between the Parties, the indemnification provision(s) in the BAA or elsewhere in the Contract shall be interpreted to relate only to matters within the scope of the BAA or those other Contract provisions.

4.5 The terms of this Section 4 shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which shall include for purposes of this Section 5 all subcontractors, agents, and employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor and nothing in this Contract shall be construed as creating a partnership, joint venture, or agency. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees, agents, and/or subcontractors in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, state and federal income tax withholding, other payroll taxes, unemployment compensation, workers' compensation, and similar matters. CONTRACTOR shall file all required returns related to such taxes, contributions, and payroll deductions.

6. Personnel.

6.1 CONTRACTOR Staffing. CONTRACTOR shall ensure that only fully qualified CONTRACTOR personnel are assigned to perform the services under the Contract, and such CONTRACTOR personnel shall perform services diligently and in a timely manner, according to the applicable professional and technical standards.

6.2 CONTRACTOR Personnel Restrictions. When on CalOptima's premises, CONTRACTOR personnel shall comply with CalOptima policies and procedures, including CalOptima's identification requirements (e.g., name badges).

6.3 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair or replacement by CONTRACTOR at no cost to CalOptima.

6.4 Neither Party shall actively solicit employees of the other Party for employment that directly or indirectly provided services under the Contract during the Term and for a period of one (1) year after termination.

7. Compensation.

7.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full compensation for the faithful performance of this Contract, the rates, charges, and other payment terms identified in Exhibit B.

7.2 CalOptima will not reimburse CONTRACTOR any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

7.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance set forth in the Contract, including in Exhibit A. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES, OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING BY CALOPTIMA UNDER THIS CONTRACT.**

7.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in Exhibit B, without the express prior written authorization of CalOptima. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR**

ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.

7.5 The maximum cumulative payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. CONTRACTOR is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise to be paid by CalOptima to CONTRACTOR due to CONTRACTOR'S failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed and pay them to the appropriate taxing authority and shall have no liability for or any obligation to refund any payments withheld.

8. Confidential Material.

8.1 During the Term, either Party may have access to confidential material or information ("**Confidential Information**") belonging to the other Party or the other Party's customers, vendors, or partners. Confidential Information includes the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements, projections, methodologies, data, reports, agreements, intellectual property, trade secrets, licensing plans, and other proprietary information, or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. CalOptima's Confidential Information also includes all user information, patient information, and clinical data that comes into CalOptima's possession, custody or control. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

8.2 For the purposes of Section 8.1, Confidential Information does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other Party's Confidential Information or proprietary information; (iv) is lawfully received from a third party that is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure, pursuant to California Public Records Act, Government Code Section 6250 *et seq*., applicable provisions of California Welfare and Institutions Code, or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

8.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers, or agents, who are bound by confidentiality obligations no less stringent than those in this Section 8, on a "need to know" basis in connection with the services performed under this Contract. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; provided, however, that the receiving Party gives reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and assists the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or court does not relieve the receiving Party of its confidentiality obligations with respect to the other Party.

8.4 CONTRACTOR shall establish and maintain environmental, safety, and facility procedures, data security procedures and other safeguards against the unauthorized access, destruction, loss, or alteration of CalOptima's Confidential Information in the possession, custody, or control of CONTRACTOR. Those security procedures and other safeguards shall be no less rigorous than those maintained by CONTRACTOR for its own information of a similar nature.

8.5 Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party or destroy all documents, notes, and other tangible materials representing the disclosing Party's Confidential Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

8.6 If a breach of the obligations under this Section 8 occurs, the injured Party may be entitled to such injunctive relief and any and all other remedies available at law or in equity. This Section 8 in no way limits the liability or damages that may be assessed against a Party if another Party breaches any of the provisions of this Section 8.

8.7 This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit protected health information ("**PHI**"). As such, no BAA is required for this Contract; provided, however, that if CONTRACTOR or its employees, agents, or subcontractors access or receive, whether intentionally or unintentionally, PHI regarding CalOptima members during the Term, CONRACTOR and its employees, agents, and subcontractors shall immediately notify CalOptima, protect such PHI from any additional disclosure, not use or disclose that PHI in any way that would violate a federal or state privacy or security law, its implementing regulations, or any other state or federal law, and execute a BAA with CalOptima, as necessary and requested by CalOptima.

9. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 *et seq.*) (the "**PRA**"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless exempt from disclosure under the provisions of the PRA. CalOptima may be required to reveal certain information pursuant to the PRA believed to be proprietary or confidential by CONTRACTOR. If CONTRACTOR discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the PRA that are not so marked. If CalOptima receives a request under the PRA that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. Within five (5) days from receipt of CalOptima's notice, CONTRACTOR shall notify CalOptima if it intends to object to production of CONTRACTOR's information; otherwise CalOptima will respond to the PRA request according to the requirements of the PRA. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including attorneys' fees, and any costs awarded to the person or entity that sought CONTRACTOR's marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR-marked material (collectively referred to for purposes of this Section 9 as "**Public Records Act Claim(s)**"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

10. Modifications. CalOptima may modify the Contract upon written notice to CONTRACTOR at any time should such modification be required by CMS, DHCS, the DMHC, or applicable law or regulation ("**Regulatory Amendment**"). Any other modifications of the Contract that are not Regulatory Amendments shall be executed only by a written amendment to the Contract, signed by CalOptima and CONTRACTOR. Execution of amendments shall be contingent upon CONTRACTOR's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for CONTRACTOR's performance.

11. Assignments.

11.1 CONTRACTOR may not assign, transfer, or delegate any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole discretion. If CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, or delegation may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, or delegation made without CalOptima's express written consent shall be void.

11.2 For purposes of this Section 11, an assignment is: (1) the change of more than fifty percent (50%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than fifty percent (50%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

12. Subcontracts. CONTRACTOR may not subcontract or delegate its obligations or the performance of services under this Contract without CalOptima's prior written consent, which CalOptima may exercise in its sole discretion. CalOptima-approved subcontractors are listed in Addendum 1 to Exhibit A.

13. Term. This Contract shall commence on the Effective Date and shall continue in full force and effect for Four (4) months ("**Term**"), unless earlier terminated, as provided in this Contract.

14. Termination.

14.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days' prior written notice. Upon termination, CalOptima shall pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

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

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

14.2.2 In the event of termination under Section 14.2.1, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items, including lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

14.3 Termination for Default. CalOptima may immediately terminate this Contract upon notice to CONTRACTOR for (i) CONTRACTOR's bankruptcy, (ii) if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR; or (iii) if CONTRACTOR makes an assignment, as defined in Section 11, for the benefit of creditors ("**Termination for Default**").

14.4 Termination for Breach. Either Party may at its option, terminate this Contract by notice to the other Party if the other Party breaches one of its obligations under this Contract and fails to cure

that breach or default within thirty (30) days after receiving notice identifying that breach, provided that the non-breaching party may terminate the Contract immediately upon written notice if the non-breaching Party reasonably determines that cure of the default within thirty (30) days is impossible. The rights described in this Section 14.4 to terminate this Contract shall be in addition to any other remedy available to the non-breaching Party, whether under this Contract or in law or equity, on account of that breach.

14.5 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3 (Insurance) or Section 8 (Confidential Material).

14.6 Effect of Termination. Upon expiration or receipt of a termination notice under this Section 14:

14.6.1 CONTRACTOR shall promptly discontinue all services (unless CalOptima's notice directs otherwise) and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs, and any other products, data and such other materials, equipment, and information, including Confidential Information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure.

14.6.2 CalOptima may take over the services and may award another party a contract to complete the services under this Contract.

14.6.3 In the event of termination under Sections 14..3, 14.4, or 14.5, either Party shall be liable for any and all reasonable costs incurred by the non-breaching Party as a result of such a termination.

15. Dispute Resolution

15.1 Meet and Confer. If either Party has a dispute arising under or related to this Contract, the Parties shall informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 15.2.

15.2 Subject to the California Government Claims Act (Cal. Gov. Code §900 *et seq.*) governing claims against public entities, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about

discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

15.3 Exclusive Remedy. With the exception of any dispute that under applicable laws may not be settled through arbitration, arbitration under Section 15.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the meet-and-confer processes.

15.4 Waiver. By agreeing to binding arbitration as set forth in Section 15.2, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

16. General Provisions.

16.1 Non-Exclusive Relationship. This is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

16.2 Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima vendor policies relating to services under the Contract that are in effect when this Contract is signed or that come into effect during the Term and are available to CONTRACTOR on CalOptima's website.

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

16.4 Time is of the Essence. Time is of the essence in performance of this Contract.

16.5 Choice of Law. This Contract shall be governed by and construed in accordance with all laws of the State of California. If any Party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in the County of Orange, California.

16.6 Force Majeure. When satisfactory evidence of a cause beyond a Party's control is presented to the other Party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the Party not performing, a Party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local governments, or a material act or omission by the other Party. A Party invoking this clause shall provide the other Party with prompt written notice of any delay or failure to perform that occurs by reason of force majeure. If the force majeure event continues for a period of Ten (10) days, the Party unaffected by the force majeure event may terminate this Contract upon notice to the other Party.

16.7 Notices. All notices required or permitted under this Contract shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth

below. Any notice not related to termination of this Contract may be submitted electronically to the address set forth below. Any Party whose address changes shall notify the other Party in writing.

To CONTRACTOR:	To CalOptima Health:
Clear Advocacy LLC	CalOptima Health
1121 L Street, Suite 700	505 City Parkway West
Sacramento, CA 95814	Orange, CA 92868
Attention: Debbie Daly	Attention: Kim Marquez
Email: Debbie@clearadvocacy.com	Email: kmarquez@caloptima.org

16.8 Notice of Labor Disputes. Whenever CONTRACTOR has knowledge that any actual or potential labor dispute may delay this Contract, CONTRACTOR shall immediately notify and submit all relevant information to CalOptima.

16.9 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the Parties agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability related to this Contract. [County of Orange Ordinance No 3896, codified in Orange County Municipal Code Section 4-11-7(a)]

16.10 Entire Agreement. This Contract, including all exhibits, addenda, and Contract Documents, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations, and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

16.11 Waiver. Any failure of a Party to insist upon strict compliance with any provision of this Contract shall not be deemed a waiver of such provision or any other provision of this Contract. To be effective, a waiver must be in a writing that is signed and dated by the Parties. A waiver by either of the Parties of a breach of any of the covenants, conditions, or agreements to be performed by the other Party shall not be construed to be a waiver of any succeeding breach of the Contract or of any other covenant or condition of the Contract. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged, or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

16.12 Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Sections 4 (Indemnification), 5 (Independent Contractor), 8 (Confidential Material), 9 (California Public Records Act), 14.6 (Effect of Termination), 15 (Dispute Resolution), 16.3 (Names and Marks), 16.5 (Choice of Law), 16.9 (No Liability of County of Orange), this Section 16.12, 16.14 (Interpretation), 16.15 (Third-Party Beneficiaries), 16.16 (Successors and Assigns) and any other Contract provisions that by their nature are intended to survive termination or expiration of this Contract.

16.13 Severability. If any section, subsection or provision of this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall remain in effect.

16.14 Interpretation. The terms of this Contract are the result of negotiation between the Parties. Accordingly, any rule of construction of contracts (including California Civil Code Section 1654) that ambiguities are to be construed against the drafting party shall not be employed in the interpretation of this Contract.

16.15 Third Party Beneficiaries. There are no intended third-party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

16.16 Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties. Nothing in this Contract is intended to confer upon any party other than the Parties or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

16.17 Without Limitation. Any reference in the Contract to "include(s)" or "including" means inclusion without limitation, unless otherwise distinguished within the text.

16.18 Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

16.19 Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

16.20 Recitals and Exhibits. The recitals, exhibits, and addenda attached to this Contract are made a part of the Contract by this reference.

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. 24-10520 on the day and year last shown below.

Clear Advocacy LLC	CalOptima Health
By: Debra Daly	By: DocuSigned by: Nancy Huang D22E3B87032946F...
Print Name: Debra Daly	Print Name: Nancy Huang
Title: Partner	Title: CFO, CalOptima
Date: 12/13/23	Date: 12/19/2023
By:	By:
Print Name:	Print Name:
Title:	Title:
Date:	Date:

EXHIBIT A
Scope of Work

1. **Description 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, city councils and other local elected officials, 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;
- 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.

16. As-needed State & Local Orange County Government Lobbyist Registrations which includes preparing and submitting quarterly State Lobbying Disclosures.

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.

2. **Standard of Performance; Warranties.**

2.1 CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

2.2 If CONTRACTOR may subcontract for services under this Contract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work and will comply with all applicable provisions of this Contract.

2.3 CONTRACTOR expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. CONTRACTOR further warrants that all material covered by this Contract, if any, which is the product of CONTRACTOR will be new and unused unless otherwise specified and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to CONTRACTOR. CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage resulting from such defects. CalOptima shall give notice to CONTRACTOR of any observed defects. If CONTRACTOR fails to adjust, repair, correct, or perform other work made necessary by such defects, CalOptima may make such adjustments, repairs, and/or corrections and charge CONTRACTOR the costs incurred.

2.4 CONTRACTOR's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

2.5 CONTRACTOR's obligations under this Section 2 are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both Parties.

2.6 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair or replacement by CONTRACTOR at no cost to CalOptima.

3. **Record Ownership and Retention.**

3.1 The originals of all letters, documents, reports, and any other products and data prepared or generated for the purposes of this Contract shall be delivered to and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

3.2 CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("**Works**"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

4. **Required Insurance**

4.1. Commercial General Liability, including contractual liability and coverage for independent contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

4.1.1. Per occurrence: $1,000,000

4.1.2. Personal Advertising Injury: $1,000,000

4.1.3. Products Completed Operations: $2,000,000

4.1.4. General Aggregate: $2,000,000

EXHIBIT A
Addendum 1

The following is a list of subcontractors approved to perform Services under this Contract:

Subcontractor Name	Functions

EXHIBIT B
Payment

1. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR for fees and expenses in accordance with the provisions of this Exhibit B and subject to the maximum cumulative payment obligations specified below.

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

3. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 24-10520; specify the number of hours worked; the specific dates the hours were worked; the description of work performed; the time period covered by the invoice and the amount of payment requested; and be accompanied by a progress report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

4. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that CalOptima's maximum cumulative payment obligation hereunder for work performed in Exhibit A of this Contract shall not exceed Forty-Nine Thousand Six Hundred Dollars ($49,600.00), including all amounts payable to CONTRACTOR for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract.

5. CONTRACTOR's monthly fixed billable rate shall be Twelve Thousand Four Hundred Dollars ($12,400.00) for work performed in Exhibit A of this Contract. This rate is fixed for the duration of the Contract. CalOptima shall not pay CONTRACTOR for time spent traveling.

6. CalOptima shall not reimburse CONTRACTOR for any travel or other related expenses under this Contract.

EXHIBIT B-1
[Not Applicable to this Contract]

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EXHIBIT C
Regulatory Requirements

CalOptima is a public agency and is licensed by the DMHC. In addition, CalOptima arranges for the provision of Medi-Cal services to Medi-Cal beneficiaries under a contract with DHCS ("**DHCS Contract**") and Medicare Advantage ("**MA**") services to Medicare beneficiaries under a contract CMS ("**CMS Contract**"). This Exhibit C sets forth the statutory, regulatory, and contractual requirements that CalOptima must incorporate into the Contract as a public agency and DMHC-licensed health care service plan with MA and Medi-Cal products.

1. **Medi-Cal Requirements.**

1.1. Compliance with Medi-Cal Standards. CONTRACTOR agrees that the Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract. CONTRACTOR shall comply with all applicable requirements of the Medi-Cal program and comply with all monitoring of the DHCS Contract and any other monitoring requests by DHCS.

1.2. Disclosure of Officers, Owners, Stockholders and Creditors. Pursuant to Exhibit E, Attachment 2, Section 33 (a) of the DHCS Contract and 42 C.F.R. Section 455.104, upon the Effective Date, on an annual basis, and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit D of this Contract and submitting the form to CalOptima:

1.2.1. All officers and owners who own greater than five percent (5%) of the CONTRACTOR;

1.2.2. All stockholders owning greater than five percent (5%) of any stock issued by CONTRACTOR; and

1.2.3. All creditors of CONTRACTOR's business if such interest is over five percent (5%).

1.3. Compliance with Employment and Labor Laws. Each Party shall, at its own expense, comply with all applicable laws in performing their respective obligations under the Contract, including, but not limited to, the National Labor Relations Act, the Americans With Disabilities Act, all applicable employment discrimination laws, overtime laws, tax laws, immigration laws, workers' compensation laws, occupational safety and health laws, and unemployment insurance laws and any regulations related thereto. CONTRACTOR acknowledges and agrees that:

1.3.1. CONTRACTOR and its subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. CONTRACTOR and its subcontractors will take affirmative action to ensure that qualified applicants are employed and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. CONTRACTOR and its subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices provided by the federal government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state CONTRACTOR and its subcontractors' obligation to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees. [DHCS Contract, Exhibit D(f), Provision 1, Section A]

1.3.2. CONTRACTOR and its subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its subcontractors, state that all qualified applicants

will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. [DHCS Contract, Exhibit D(f), Provision 1, Section B]

1.3.3. CONTRACTOR and its subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State of California, advising the labor union or workers' representative of CONTRACTOR and its subcontractors' commitments under this Section 1.3 and shall post copies of the notice in conspicuous places available to employees and applicants for employment. [DHCS Contract, Exhibit D(f), Provision 1, Section C]

1.3.4. CONTRACTOR and its subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212), and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", and of the rules, regulations, and relevant orders of the Secretary of Labor. [DHCS Contract, Exhibit D(f), Provision 1, Section D]

1.3.5. CONTRACTOR and its subcontractors will furnish all information and reports required by Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246, Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders. [DHCS Contract, Exhibit D(f), Provision 1, Section E]

1.3.6. If CONTRACTOR and its subcontractors' do not comply with the requirements of this Section 1.3 or with any federal rules, regulations, or orders referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246, as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law. [DHCS Contract, Exhibit D(f), Provision 1, Section F]

1.3.7. CONTRACTOR and its subcontractors will include the provisions of this Section 1.3 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor. CONTRACTOR and its subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that if CONTRACTOR and its subcontractors become involved in, or are threatened with litigation by a subcontractor as a result of such direction by DHCS, CONTRACTOR and its subcontractors may request in writing to DHCS, which, in turn, may request the United States to enter into such litigation

to protect the interests of the State of California and of the United States. [DHCS Contract, Exhibit D(f), Provision 1.G]

1.4. Debarment and Suspension Certification.

1.4.1. By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable federal suspension and debarment regulations, including, as applicable, 7 C.F.R. 3017, 45 C.F.R. 76, 40 C.F.R. 32, or 34 C.F.R. 85. [DHCS Contract, Exhibit D(f), Provision 20, Section A]

1.4.2. By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

1.4.2.1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any state or federal department or agency; [DHCS Contract, Exhibit D(f), Provision 20, Section B.1]

1.4.2.2. Have not within a three (3)-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction; violation of federal or state anti-trust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; [DHCS Contract, Exhibit D(f), Provision 20, Section B.2]

1.4.2.3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the offenses enumerated in Section 1.4.2.2 of this Exhibit C; [DHCS Contract, Exhibit D(f), Provision 20, Section B.3]

1.4.2.4. Have not within a three (3)-year period preceding the Effective Date of this Contract had one or more public transactions (federal, state or local) terminated for cause or default; [DHCS Contract, Exhibit D(f), Provision 20, Section B.4]

1.4.2.5. Have not and shall not knowingly enter into any lower-tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 C.F.R. 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State of California; and [DHCS Contract, Exhibit D(f), Provision 20, Section B.5]

1.4.2.6. Will include a clause entitled, "Debarment and Suspension Certification" that sets forth the provisions herein in all lower-tier covered transactions and in all solicitations for lower-tier covered transactions. [DHCS Contract, Exhibit D(f), Provision 20, Section B.6]

1.4.3. If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima. [DHCS Contract, Exhibit D(f), Provision 20, Section C]

1.4.4. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549. [DHCS Contract, Exhibit D(f), Provision 20, Section D]

1.4.5. 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. [DHCS Contract, Exhibit D(f), Provision 20, Section E]

1.5. Lobbying Restrictions and Disclosure Certification.

1.5.1. *Certification and Disclosure Requirements.*

1.5.1.1. If Contract is subject to 31 U.S.C. § 1352 and exceeds $100,000 at any tier, CONTRACTOR and its subcontractors, as applicable, shall file a certification (in the form set forth in Exhibit E, consisting of one page, entitled "Certification Regarding Lobbying") that CONTRACTOR and its subcontractors, as applicable, have not made, and will not make, any payment prohibited by Section 1.5.2 below. [DHCS Contract, Exhibit D(f), Provision 35, Section A.1; 31 U.S.C. § 1352]

1.5.1.2. CONTRACTOR and its subcontractors, as applicable, shall file a disclosure (in the form set forth in Exhibit E, entitled "Certification Regarding Lobbying") if CONTRACTOR and its subcontractors, as applicable, have made or agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with the Contract or a subcontract thereunder that would be prohibited under Section 1.5.2 below if paid for with appropriated funds. [DHCS Contract, Exhibit D(f), Provision 35, Section A.2]

1.5.1.3. CONTRACTOR and its subcontractors, as applicable, shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by CONTRACTOR and its subcontractors, as applicable, under this Section 1.5.1. An event that materially affects the accuracy of the information reported includes: [DHCS Contract, Exhibit D(f), Provision 35, Section A.3]

1.5.1.3.1. A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action; [DHCS Contract, Exhibit D(f), Provision 35, Section A.3.a]

1.5.1.3.2. A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or [DHCS Contract, Exhibit D(f), Provision 35, Section A.3.b]

1.5.1.3.3. A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action. [DHCS Contract, Exhibit D(f), Provision 35, Section A.3.c]

1.5.1.3.4. As applicable and required by this Section 1.5, CONTRACTOR's subcontractors shall file a certification and a disclosure form, if required, to the next tier above. [DHCS Contract, Exhibit D(f), Provision 35, Section A.4]

1.5.1.3.5. All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by CONTRACTOR. CONTRACTOR shall forward all disclosure forms to CalOptima. [DHCS Contract, Exhibit D(f), Provision 35, Section A.5]

1.5.2. *Prohibition.* 31 U.S.C. § 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. [DHCS Contract, Exhibit D(f), Provision 35, Section B]

1.6. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of CalOptima, the Secretary of Health and Human Services Office of Inspector General, the Comptroller General of the United States, the U.S. Department of Justice, DHCS, the DMHC, the Bureau of Medical Fraud, or any of their duly authorized representatives copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement with a CONTRACTOR subcontractor or an organization related to a CONTRACTOR subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records 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. [DHCS Contract, Exhibit E, Attachment 2, Provision 20]

1.7. Confidentiality of Member Information.

1.7.1. If CONTRACTOR and its employees, agents, or subcontractors access or receive, whether intentionally or unintentionally, personally identifying information during the Term, CONTRACTOR and its employees, agents, and subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out the express terms of and CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information, except requests for medical records in accordance with applicable law, not emanating from the CalOptima member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the CalOptima member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima specifying that the information is releasable under Title 42 C.F.R. Section 431.300 *et seq.*, Section 14100.2, Welfare and Institutions Code, and regulations adopted there under. For purposes of this Section 1.7, identity shall include name, identifying number, symbol, or other identifying detail assigned to the individual, such as finger or voice print or a photograph. [DHCS Contract, Exhibit D(F), Provision 12, Exhibit E, Attachment 2, Provision 22, Section B]

1.7.2. Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 C.F.R. Section 431.300 *et seq.*, Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to CalOptima members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a CalOptima member under this Contract that is obtained by CONTRACTOR or its subcontractors, CONTRACTOR will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose. [DHCS Contract, Exhibit E, Attachment 2, Provision 22]

1.8. Member Hold Harmless. To the extent CONTRACTOR provides services or supplies to CalOptima members, CONTRACTOR hereby agrees that in no event, including nonpayment by CalOptima, the insolvency of CalOptima, or breach of the Contract, shall CONTRACTOR bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against CalOptima members, persons acting on their behalf, or DHCS. CONTRACTOR further agrees that this hold harmless provision shall survive the termination of the Contract regardless of the cause giving rise to the termination, shall be construed to be for the benefit of CalOptima members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between CalOptima or CONTRACTOR and a CalOptima member or persons acting on their behalf that relates to liability for payment for services under the Contract. [DHCS Contract, Exhibit A, Attachment 6, Provision 13, Section B.15; CMS Medicare Managed Care Manual Chapter 11, Section 100.4]

1.9. Member Grievances. CONTRACTOR shall cooperate with CalOptima's member grievances and appeals procedures as necessary for CalOptima to carry out its legal obligations. [DHCS Contract, Exhibit A, Attachment III § 4.6; 28 C.C.R. §§ 1300.68, 1300.68.01; 22 CCR § 53858; 43 C.F.R. § 438.402-424]

1.10. Air and Water Pollution Requirements. If this Contract or any subcontract thereunder is in excess of one hundred thousand dollars ($100,000), CONTRACTOR agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 *et seq.*), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 *et seq.*), as amended. [DHCS Contract, Exhibit D(f), Provision 12]

2. **Medicare Requirements.**

2.1. CONTRACTOR expressly warrants that CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with all applicable Medicare laws, regulations, and CMS instructions. CONTRACTOR further agrees and acknowledges that this provision will be included in all agreements with CONTRACTOR's subcontractors.

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

2.2.1. Abide by all federal and state laws regarding confidentiality and disclosure of medical records and other health and enrollment information. CONTRACTOR shall safeguard the privacy of any information that identifies a particular enrollee and shall have procedures that specify: (a) the purposes for which the information will be used within CONTRACTOR's organization; and (b) to whom and for what purposes CONTRACTOR will disclose the information.

2.2.2. Ensure that the medical information is used and released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas.

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

2.3. CONTRACTOR shall comply with the reporting requirements provided in 42 C.F.R. § 422.516, as well as the encounter data submission requirements in 42 C.F.R. § 422.257.

2.4. For all contracts in the amount of $100,000 or more, CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with 41 C.F.R. 60-300.5(a) and 41 C.F.R. 60-741.5(a) as follows:

2.4.1. CONTRACTOR and its subcontractors shall abide by the requirements of 41 C.F.R. § 60-300.5(a). This regulation prohibits discrimination against qualified protected veterans and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified protected veterans. [41 C.F.R. § 60-300.5(d)]

2.4.2. CONTRACTOR and its subcontractors shall abide by the requirements of 41 C.F.R. § 60-741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities. [41 C.F.R. § 60-741.5(d)]

2.5. In addition to the termination provisions of Section 14 of the Contract, CalOptima may terminate the Contract if CMS or CalOptima determines that CONTRACTOR has not satisfactorily performed its obligations under the Contract. Under such circumstances, CalOptima may pay CONTRACTOR its allowable costs incurred to the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima for matters pertaining to this Contract.

2.6. While CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of the CMS Contract, CONTRACTOR shall comply with all such applicable requirements in the CMS Contract, at the direction of CalOptima.

2.7. CONTRACTOR shall ensure that the persons it employs or contracts with for the provision of services pursuant to the Contract are in good standing and not on the preclusion list, defined in 42 C.F.R. § 422.2. CONTRACTOR shall promptly disclose to CalOptima any exclusion or other event that makes a CONTRACTOR employee or subcontractor ineligible to perform work related to federal health care programs. CONTRACTOR agrees to be bound by the provisions set forth at 2 C.F.R. Part 376. [42 C.F.R. § 422.752(a)(8)]

3. **Offshore Performance.**

3.1. Due to security and identity protection concerns, direct services under this Contract shall not be performed by offshore subcontractors, unless otherwise authorized in writing by CalOptima prior to the provision of those services.

3.2. CONTRACTOR shall complete, sign, and return Exhibit G, "Attestation Concerning the Use of Offshore Subcontractors" as of the Effective Date and shall submit an executed Offshore Subcontractor Attestation to CalOptima no less than annually thereafter. CONTRACTOR represents and warrants that it has disclosed in Exhibit G any and all such offshore subcontractors and that it has obtained CalOptima's written approval to use such offshore subcontractors prior to the Effective Date.

3.3. Any subcontract with an offshore entity under which the offshore entity will have access to any confidential CalOptima member or other protected health information must be approved in writing by CalOptima prior to execution of the subcontract. CONTRACTOR is required to submit future Offshore Contractor Attestations to CalOptima within thirty (30) calendar days after it has signed a contract with any subcontractor that may be using an offshore subcontractor to perform any related work.

3.4. Unless specifically stated otherwise in this Contract, the restrictions of this Section 3 do not apply to indirect or "overhead" services, or services that are incidental to the performance of the Contract.

3.5. The provisions of this Section 3 apply to work performed by subcontractors at all tiers.

4. **Prohibited Interest.**

4.1. CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict-of-interest laws, including CalOptima's Conflict of Interest Code, the California Political Reform Act (California Government Code § 81000 *et seq.*) and California Government Code § 1090 *et seq.* (collectively, the "**Conflict of Interest Laws**").

4.2. CONTRACTOR covenants that, to the best of its knowledge during the Term, no director, officer, or employee of CalOptima during his or her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the Term, and consistent with the provisions

of 22 C.C.R. § 53600(f), no state officer or state employee shall be employed in a management or contractor position by CONTRACTOR within one (1) year after the state office or state employee has terminated state employment.

4.3. CONTRACTOR, and any person designated by CONTRACTOR to make or participate in making a governmental decision on behalf of CalOptima, is considered a "**Consultant**" pursuant to CalOptima's Conflict of Interest Code and shall be required to file a statement of economic interests (Fair Political Practices Commission Form 700) with CalOptima annually. [2 C.C.R. Section 18734]

4.4. CONTRACTOR understands that if this Contract is made in violation of California Government Code § 1090 *et seq*., the entire Contract is voidable, CONTRACTOR will not be entitled to any compensation for services performed pursuant to this Contract, and CONTRACTOR will be required to reimburse CalOptima any sums paid to CONTRACTOR. CONTRACTOR further understands that CONTRACTOR may be subject to criminal prosecution for a violation of California Government Code § 1090.

4.5. If CONTRACTOR becomes aware of any facts that might reasonably be expected to either create a conflict of interest under the Conflict of Interest Laws or violate the provisions of this Section 4, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include identification of all persons, entities, and businesses implicated and a complete description of all relevant circumstances.

5. **State Auditor Audit Disclosure**. Pursuant to California Government Code § 8546.7, if this Contract is more than ten thousand dollars ($10,000), it is subject to examination and audit of the California State Auditor, at the request of CalOptima or as part of any audit of CalOptima for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract, CONTRACTOR agrees that during the Term and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period. [Gov't Code § 8546.7]

EXHIBIT D
Medi-Cal Disclosure Form

Contractor Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: CLEAR ADVOCACY

Business Entity Type: LLC
(Sole Proprietorship, Partnership, LLC, California Corporation, etc.)

Business Address: 1121 L Street, Suite 700

City: Sacramento State: CA Zip: 95814

Business Phone: (714) 612-6861 Email: : Debbie@ClearAdvocacy.com

President: Debra Daly, Partner Contact Person: Debra Daly

Person(s) Signing Contract & Title: : Debra Daly, Partner

*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 %
Tom Daly	Partner/50%
Debra Daly	Partner/50%

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.

Debra Daly
Authorized Signature

12/13/23
Date

DEBRA DALY
Name and Title

EXHIBIT E

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this federal contract, federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this federal contract, grant, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities"' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

CLEAR ADVOCACY Name of Contractor	Debra Daly Printed Name of Person Signing for Contractor
CalOptima Contract #24-10520 Contract/Grant Number	Debra Daly Signature of Person Signing for Contractor
12/13/23 Date	Partner Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

CERTIFICATION REGARDING LOBBYING

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

Approved by OMB 0348-0046

1. Type of Federal Action: N/A ☐a. contract ☐b. grant ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	2. Status of Federal Action: N/A ☐a. bid/offer/application ☐b. initial award ☐c. post-award	3. Report Type: N/A ☐a. initial filing ☐b. 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: N/A	7. Federal Program Name/Description: N/A CDFA Number, *if applicable:*
8. Federal Action Number, *if known:* NONE	9. Award Amount, *if known:* $_____
10. a. Name and Address of Lobbying Entity *(If individual, last name, first name, MI):* CLEAR ADVOCACY 1121 L Street, Suite 700 Sacramento, CA 95814 *(attach Continuation Sheet(s) SF-LLLA, if necessary)*	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):
11. Amount of Payment (check all that apply): $_____ ☐actual ☐planned 12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature _____ Value _____	13. Type of Payment ☐ 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 $10,000 and not more than $100,000 for each such failure.	Signature: Debra Daly Print Name: Debra Daly Title: Partner Telephone No.: (714) 612-6861 Date: 12/13/23

Federal Use Only | Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.
2. Identify the status of the covered federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.
4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.
5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.
6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.
7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."
9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.
10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.
12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.
13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.
14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.
16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

EXHIBIT F

[Not Applicable to this Contract]

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EXHIBIT G

CalOptima
Better. Together

Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima prior to entering into or amending any agreement with an Offshore Subcontractor, and Contractor must complete the Offshore Subcontracting Attestation.

Which CalOptima program(s) does this form pertain to? Select all that apply.	X OneCare Connect X PACE X OneCare X Medi-Cal

Please check one of the following:

X Our Organization does not offshore any protected health information.
Please skip to Part V below

☐ Our Organization does offshore protected health information.
Please complete Offshore Subcontractor Attestation (Part I through Part V) below

Part I — Offshore Subcontractor Information

Attestation	Response
Our Organization uses an offshore subcontractor or offshore staff to perform functions that support our contract with CalOptima	☐ Yes ☐ No
Offshore Subcontractor name:	
Offshore Subcontractor country:	
Offshore Subcontractor address:	
Describe offshore subcontractor functions:	
Proposed or actual effective date for offshore subcontractor (MM/DD/Year):	

Part II — Precautions for Protected Health Information (PHI)

Question	Response
1. Describe the PHI that will be provided to the offshore subcontractor	
2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's objectives:	
3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

CalOptima
Better Together

Part III — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract	
Attestation	**Response**
A. Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary protected health information (PHI) and other personal information remains secure.	Yes No*
B. Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with CalOptima's contract with the offshore subcontractor.	Yes No*
C. Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	Yes No*
D. Offshore subcontracting arrangement includes all required Medicare Part C and D language (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.)	Yes No*

Part IV — Attestation of Audit Requirements to Ensure Protection of PHI	
Attestation	**Response**
A. Our Organization will conduct an annual audit of the offshore subcontractor/employee.	Yes No*
B. Audit results will be used by our Organization to evaluate the continuation of its relationship with the offshore subcontractor/employee.	Yes No*
C. Our Organization agrees to share offshore subcontractor's/employee's audit results with CalOptima or CMS upon request.	Yes No*

*Explanation required for all "no" responses to Part III and Part IV above:

Part V — Organization Information	
By signing below, I hereby attest that the information contained herein is true, correct and complete.	
Printed name of authorized person: Debra Daly	Title: Partner
Email: Debbie@ClearAdvocacy.com	Phone #: (714) 612-6861
Signature: Debra Daly	Date: 12/13/23

Note: CalOptima's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima's Code of Conduct, CalOptima's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.asp

EXHIBIT H
[Not Applicable to this Contract]

CalOptima Health Board Action Agenda Referral

Action To Be Taken February 1, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

11. Ratify and Authorize Actions Related to Contracts for Professional Services to Support Information Technology Services.

Contact

Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

1. Ratify the contract amendment and additional scope of work with Accenture LLP (Accenture) for Digital Transformation Consulting; and
2. Authorize the Chief Executive Officer to:
    a. Develop and release a request for proposals (RFP) for professional services to support the implementation of the Digital Transformation Strategy;
    b. Negotiate and execute a contract with the selected vendor; and
    c. Reallocate unspent budgeted funds from Fiscal Year 2023-24 Digital Transformation Year Two Operating Budget to fund the administrative expenses in the current fiscal year.

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

As part of the development of the Digital Transformation Strategy, CalOptima Health contracted with Accenture to conduct an assessment and develop a multi-year implementation roadmap. In December 2023, CalOptima Health amended the contract with Accenture to add additional deliverables to the scope of work, including a resource plan to accompany the roadmap, an ITS operating model to support the execution and sustainability of the plan, and resources to launch a technology governance model. Accenture was uniquely positioned to provide this additional scope of work as the new deliverables were tied to the outcomes of the initial contract with Accenture. The only other effective option for delivery of the additional deliverables would have been to conduct the work with CalOptima Health resources. Given the limited internal resources for this work, CalOptima Health chose to extend the scope of work with Accenture.

Back to Agenda

Following Accenture's delivery of a multi-year roadmap, CalOptima Health now seeks approval to solicit proposals from qualified vendors to support in the implementation of large initiatives. The initiatives will include data governance and customer engagement.

Staff will procure a vendor contract through the RFP process in accordance with CalOptima Health Policy GA.5002: Purchasing Policy, and requests authority to fund administrative expenses related to the selected vendor contract for the current fiscal year through reallocation of unspent budgeted funds within the Fiscal Year (FY) 2023-24 Digital Transformation Year Two Operating Budget.

Fiscal Impact

The estimated current fiscal year budget shortfall related to the contract amendment is approximately $150,000. Unspent budgeted funds from the FY 2023-24 Digital Transformation Year Two Operating Budget will fund the contract amendment.

Management will include additional administrative expenses related to the contract to support the implementation of the Digital Transformation Strategy in the FY 2024-25 Digital Transformation Year Three Operating Budget.

Rationale for Recommendation

The recommended actions allow CalOptima Health to continue to pursue the Digital Transformation Strategy to increase value, effectiveness and efficiency for members, providers and employees.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Accenture Contract Amendment 1

/s/ Michael Hunn *01/25/2024*
Authorized Signature **Date**

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AMENDMENT NO. 1 TO CONTRACT 24-10292
BY AND BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, dba CALOPTIMA HEALTH A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA HEALTH
(CalOptima Health)
AND
ACCENTURE LLP
(CONTRACTOR)

AMENDMENT NO. 1 TO THIS CONTRACT is entered into as 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 24-10292 on September 18, 2023, under which CONTRACTOR agreed to provide Digital Transformation Consulting as described in the Scope of Work (hereinafter, "Contract").

B. Pursuant to Section 10 of the Contract, the Contract may only be amended in writing executed by the Parties.

C. The Parties now desire to amend the Contract to incorporate additional Scope of work and increase funding.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. The Parties now agree to amend Exhibit A of the Contract to incorporate the additional Scope of Work described in Addendum No. 1 attached to this Amendment. CONTRACTOR agrees to provide the Services according to the schedule in Addendum No. 1 and time is of the essence for this project as set forth in Section 16.5 of the Contract.

2. The Parties now agree to amend Exhibit B of the Contract to increase the maximum cumulative payment obligation by Two Hundred Fifty Thousand Dollars ($250,000.00). CalOptima Health agrees to the milestone payment schedule in Addendum No. 1. The new maximum cumulative payment obligation under the Contract is increased to One Million One Hundred Forty-Five Thousand Dollars ($1,145,000.00).

3. **No Other Changes**. This Amendment No. 1 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. 1 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.

4. **Authority to Execute.** The persons executing this Amendment on behalf of the Parties warrant that they are duly authorized to execute this Amendment and that by executing this Amendment, the Parties are formally bound.

5. **Counterparts**. This Amendment may be executed in any number of counterparts, all of which taken together shall constitute one and the same instrument, and any of the Parties hereto may execute the Amendment by signing any such counterpart.

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[Signatures on following page]

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 1 on the day and year last shown below.

ACCENTURE LLP

Signature: DocuSigned by: Lisa Caplan 659EB9DC6AE2409...

Name: Lisa Caplan

Title: Managing Director

Date: January 3, 2024

Signature: _____

Name: _____

Title: _____

Date: _____

CALOPTIMA HEALTH

Signature: DocuSigned by: Nancy Huang D22E3B87032946E...

Name: Nancy Huang

Title: CFO, CalOptima

Date: 01/04/2024

Signature: DocuSigned by: Michael Hunn EDDDDCC19C894FB...

Name: Michael Hunn

Title: CEO

Date: 01/04/2024

If CONTRACTOR is a corporation, two officer signatures or Corporate Resolution or Corporate Seal is required.

Addendum No. 1
Scope of Work (SOW)

Under this SOW, Contractor will perform strategic consulting services in support of CalOptima's ITS Digital Transformation efforts (the "Services").

1. **Services Start Date:** January 15, 2024
2. **Services End Date:** March 8, 2024
3. **Description of Scope, Services, Deliverables:**

   The following are the Services to be provided by Contractor under this SOW:
   a) Develop an organizational resource plan to accompany the recently completed ITS Digital Strategic Plan
   b) Update the ITS Digital Strategic Plan with any required modifications based on resource availability, required contracting periods, or other business considerations.
   c) Create a high-level ITS Operating Model to support execution of the ITS Digital Strategic Plan
   d) Support launch of the new Technology Governance process/forums

4. **Deliverables:**

The following table outlines the deliverables that Contractor will create as part of the Services.

Deliverable	Timeframe and Frequency
Weekly Status Reports	January 2024 – February 2024, Weekly
Resource Plan for ITS Digital Transformation Strategic Plan	January 2024-February 2024
High-Level ITS Operating Model	January 2024 - February 2024
Updated ITS Digital Transformation Strategic Plan	February 2024
Technology Governance: - Launch Presentation - Meeting Agenda(s) - Action Items	January 2024-February 2024, based on meeting scheduling

5. Staffing and Work Arrangements: The Contractor team members shall perform Services to complete the identified deliverables within two (2) months of the Services start date (the "SOW Term"). Contractor staff will generally perform Services on a remote basis, attending in-person for key meetings. Contractor's project roles and description are listed below.

Role	Description
Engagement Lead	Responsible for overall delivery success, serving as an executive advisor, reviewing all deliverables, and attending key meetings/work sessions
Technology Strategy Lead	Participates in development of deliverables and key meetings utilizing domain subject matter expertise.
Project Manager	Responsible for all project management services including creation of deliverables, status reporting, and management of key meetings.
Project Consultant	Responsible for creation of deliverables with assistance from above team members.

6. Assumptions:

6.1. All deliverables will be completed no later than March 8, 2024. Any resource extensions beyond this date will follow the change order processes in the Contract.

6.2. CalOptima will be responsible for providing meeting access to project team members and document repository.

6.3. CalOptima will commit the necessary resources to support completion of deliverables.

6.4. CalOptima will be responsible for the contractual relationship with third parties and for ensuring that they cooperate with the Contractor team.

6.5. CalOptima will be responsible for timely review and acceptance of Services and deliverables.

6.6. Contractor's work will be under the direction of CalOptima's Chief Operating Officer, who will serve as the Project Executive for the project.

6.7. Contractor shall not be required to access or use any CalOptima data that identifies or directly relates to natural persons, as defined in applicable data privacy law, as part of the Services.

7. Cost and Fees.

Total fees for the Services listed within this Addendum No. 1 to Amendment No. 1 to Contract 24-10292 shall not exceed Two Hundred Fifty Thousand Dollars ($250,000.00), unless Contractor and CalOptima mutually agree, in writing, to specific change orders.

The fees under this SOW are based upon the Contractor fixed resource capacity described in Section 5. If at any time during the SOW Term either Party determines that the Services cannot reasonably be completed by the Contractor resources during the SOW Term within the fixed resource capacity, the Parties agree to adjust the Services such that they can be completed during the SOW Term by the Contractor resources, or the Parties will agree to an equitable adjustment to the Contractor resource capacity and timeframe through the change control process in the Contract. For clarity, in the event the required work effort exceeds the fixed resource capacity and the associated fixed fees, Contractor shall have no obligation to continue performing the Services absent a change order executed in accordance with the change control process authorizing additional capacity and associated fees.

Contractor shall not incur, nor will CalOptima reimburse for, any travel or other related expenses in connection with the work outlined above.

The table below outlines the payment schedule:

Month	Deliverables	Fees	Invoice Date
1	January Weekly Status Reports Draft Resource Plan Draft High-Level IT Operating Model Technology Governance January Meeting Materials	$125,000	After 1/31/2024 Deliverable
2	February Weekly Status Reports Finalized Resource Plan Finalized High-Level IT Operating Model Technology Governance February Meeting Materials Updated IT Digital Transformation Strategic Plan	$125,000	Upon completion of all deliverables
Travel Expenses		N/A	
Grand Total		**$250,000**	

CalOptima Health Board Action Agenda Referral

Action To Be Taken February 1, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

12. Authorize Utilization of a Customized Contract to Execute an Amendment with Sitecore

Contacts

Deanne Thompson, Executive Director, Communications, (714) 954-2141
Rick Cabral, Associate Director, Information Technology Services, (714) 347-5788

Recommended Action

Authorize the Chief Executive Officer (CEO) to utilize a customized contract to negotiate and execute an amendment to the agreement with Sitecore for web content management and digital experience software platform.

Background

The CalOptima Health Board of Directors (Board) has authorized the use of a standard contract template; however, in cases where no vendors are willing to accept the standard contract template, Board authorization is required to enter into a customized contract with an otherwise responsive vendor.

Discussion

The Web Content Management and Digital Experience Platform (CM/DXP) solution will provide CalOptima Health's staff with a modern set of tools to build and manage websites that provide website visitors with personalized content and experiences based on their needs. This will allow CalOptima Health members and providers to get the information they seek quickly when they visit CalOptima Health's website. The new solution will leverage the user's activities on CalOptima Health's website to gain insights into user needs and provide them with tailored information. Capabilities of CM/DXP solutions have increased dramatically over the past decade since CalOptima Health originally implemented its current content management solution. Implementing a modern CM/DXP solution will lead to better website content design and delivery, provide for improved usage of CalOptima Health's websites and portals, and make information about CalOptima Health programs and services easier for members and providers to access and utilize.

In 2009, CalOptima Health licensed the on-premise Sitecore Web Content Management (CM) system to implement the www.CalOptima.com website. Migrating to a cloud based Web CM was a priority in the digital transformation project. On December 21, 2022, using the bid exception process, CalOptima Health replaced the on-premise Sitecore contract with a new agreement for website content management and hosting services for two years to allow for time to transition to a full Software as a Service (SaaS) solution. The current end date of the agreement is December 21, 2024.

On December 29, 2022, the CalOptima Health ITS and Communications teams worked in conjunction with Vendor Management to issue a request for proposals (RFP) for a CM/DXP that would provide enhanced personalization and member experience by modernizing CalOptima Health's technology platform. The RFP requested that bidders provide the software licenses and hosting services. CalOptima

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Health received six bids. The incumbent, Sitecore, was disqualified because it did not fill out the request to negotiate as required by the RFP process. Staff eliminated two other vendors for not meeting the RFP requirements. Staff selected the remaining three vendors for demonstrations – Oxycon, Slalom, and American Eagle. After the demos, staff eliminated Oxycon for not meeting CalOptima Health's requirements and disqualified Slalom because it did not propose to provide the software license and hosting portion of the RFP. CalOptima Health selected American Eagle, but American Eagle later informed CalOptima Health that it did not intend to resell the software license either. Through discussions with American Eagle, the company agreed to resell the software licenses and hosting but would need to add terms and conditions that were not part of the original proposal. This led to American Eagle's disqualification as well.

At that point, all vendors that could meet CalOptima Health requirements were disqualified. With guidance from legal counsel, staff issued an Informal RFP on December 4, 2023, to two of the original bidders, Sitecore and American Eagle. The incumbent, Sitecore, bid on the licensing and hosting components of the RFP only. American Eagle provided a bid for implementation as well as licensing and hosting. Staff selected Sitecore for the licensing and hosting services using a customized contract template and sales order. Staff anticipate implementation of the new CM/DXP software will commence by March 2024. The existing Sitecore Web CM platform will stay in place until the new CM/DXP platform is fully implemented.

Staff recommends that the Board authorize the CEO to negotiate and execute an amendment to the agreement with Sitecore, utilizing a vendor-specific contract template with revisions that reflect the negotiated and agreed-upon terms and conditions with Sitecore. Staff anticipates the amendment will extend the end date of the agreement for three years, with two (2) one-year extensions, each exercisable at CalOptima Health's sole discretion and reviewed by staff and legal counsel, prior to execution.

Fiscal Impact

The recommended action is a budgeted item and is included in the Fiscal Year (FY) 2022-23 Digital Transformation Year One Capital Budget approved by the Board on June 2, 2022, and the FY 2023-24 Digital Transformation Year Two Capital and Operating Budgets approved by the Board on June 1, 2023. Management will include this project in future operating budgets.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. Existing Sitecore Master Services Agreement
3. CalOptima Health Order Form

/s/ Michael Hunn *01/25/2024*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Sitecore USA Inc.	101 California St. Suite 1600	San Francisco	CA	94111

CalOptima
A Public Agency
Better. Together.

Orange, CA 92868
(714) 246-8400

Purchase Order No	23-10202
PO Date	12/20/2022
Delivery Date	9/21/2022
Buyer	Lisa Ha
FOB	BEST METHOD
Shipping Point	Orange
Payment Terms	Net 30 Days
Shipping Method	Best Method
Page	1

Vendor: Sitecore USA Inc
101 California St, Suite 1600
San Francisco CA 94111

Phone: (000) 000-0000 Ext. 00(
Fax: (000) 000-0000 Ext. 00(

Ship To: CalOptima
505 City Parkway West
Orange CA 92868

^ Changed Since The Previous Revision

Number	Qty	Item U/M	Stock Number	Description	Unit Price	Extended Price
1	1	Each	SUP-075-1117	**Sitecore 360** Reference Sitecore Customer Order & MSTC Term Date: 12/29/2022 - 12/28/2023	$114,343.00	$114,343.00
2	1	Each	SUP-075-1117	**Sitecore 360** Reference Sitecore Customer Order & MSTC Term Date: 12/29/2022 - 12/28/2023	$34,291.40	$34,291.40
3	10,000	Each	SER-061-373	**SiteCore - Pofessional Fees** Reference Sitecore Customer Order & MSTC	$1.00	$10,000.00

Req #: R:31782,32346

Subtotal	$158,634.40
Trade Discount	$0.00
Freight	$0.00
Miscellaneous	$0.00
8.00% Sales Tax	$0.00
Order Total	$158,634.40

Verbal additions, deletions, or modifications of any kind to this purchase order shall be considered unauthorized and invalid. Do not accept verbal modifications from any employee, agent, or implied or apparent agent of CalOptima. Valid modifications to this purchase order shall be in the form of a written notice signed by an authorized member of the CalOptima Procurement staff.

Invoices received in excess of the total amount of this purchase order shall be considered unauthorized and, as such, may not be paid. Terms and conditions appearing on the reverse side are hereby incorporated.

PO NUMBER MUST APPEAR ON PACKING SLIP.

TO ASSIST WITH RECEIPT OF GOODS AND ENSURE PAYMENT OF VENDOR INVOICE(S), ALL ITEMS BEING DELIVERED DIRECTLY TO CALOPTIMA FROM THE MANUFACTURER MUST INDICATE CALOPTIMA'S PURCHASE OPTIMA'S PURCHASE ORDER NUMBER ON THE PACKING SLIP.

DocuSigned by:
Michael Hunn
EDDDDC[illegible]4B

Authorized Signature — Date: 12/20/2022

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Sitecore Customer Order

Customer:	Orange County Health Authority, a public agency dba CalOptima Health ("CalOptima")
Customer Address:	505 City Parkway West Orange, California, United States 92868
Billing Address:	505 City Pkwy W Orange, California, United States 92868-2924
Shipping Address:	505 City Pkwy W Orange, California, United States 92868-2924
Company/Tax ID No:	N/A
Sitecore:	Sitecore USA, Inc.
Address:	101 California St, Suite 1600 San Francisco, CA, USA 94111
Customer Accounts Payable Contact Name:	Accounts Payable
Customer Accounts Payable Contact Email:	accountspayable@caloptima.org
Customer Accounts Payable Contact Phone:	(714) 246-8400
Customer Technical Contact Name:	Eric Chow
Customer Technical Contact Email:	echow@caloptima.org

This Order is subject to the Master Terms (master subscription terms and conditions) between Sitecore USA, Inc. and CalOptima executed simultaneously with this Order, including any cloud addendum entered into by the parties, if applicable (collectively, the "Master Terms"). This Order will be effective on December 29, 2022 (the "**Order Effective Date**"). Unless otherwise defined in this Order, capitalized terms shall have the meanings set forth in the Master Terms. This Order is voidable at Sitecore's option if not signed by Customer on or before December 21st, 2022.

1. Summary of Sitecore Products

SOFTWARE

As of the Order Effective Date, Sitecore will provide the following Software to Customer:

Quantity	Description
1	Sitecore Experience Manager (Corporate)

Entitlement	Entitlement Value	Overage Measure	Overage Rate
Visits/year Year 1	2,000,000	Per 1,000,000 visits	62050.28 USD
Visits/year Year 2	2,000,000	Per 1,000,000 visits	62050.28 USD
Domains	25	N/A	N/A
Production Environment(s)	1	N/A	N/A

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Non Production Environment(s)	5	N/A	N/A
Concurrent Users	25	N/A	N/A

As of the Order Effective Date and subject to the terms of the Master Terms, the Former License and its maintenance program are terminated. Sitecore and Customer hereby agree to fully replace and supersede the Former License with this Order Form and the Master Terms. "**Former License**" means the following Sitecore license: License ID#20090430145444 – Purchased April 30, 2009, including the terms and conditions governing such license, and any and all subsequent amendments or addenda thereto.

Licensing is enabled by electronic delivery of a License Key. Promptly after mutual execution of this Order, a new License Key will be shipped to Eric Chow at echow@caloptima.org, and any license keys associated with the Former License will be terminated. Notwithstanding Section 4(c) of the Agreement, the License Key will not be time-limited.

Permitted Usage. Customer may use the Software for creation and management of Customer's own current and future public-facing web properties.

No later than the 15th calendar day following each 12-month period beginning from the Order Effective Date Customer will submit to Sitecore a usage report identifying the number of Visits in that 12-month period based on Customer's use of the Software (the "Annual Usage Report"). Where the Annual Usage Report indicates that Customer has exceeded its purchased number of Visits, Sitecore will issue in invoice to Customer for such excess usage calculated using the Overate Measure and Overage Rate detailed in the table above.

Where Customer is not able to use the Software for monitoring Visits, Customer will use appropriate monitoring software reasonably acceptable to Sitecore to produce the Annual Usage Report.

SAAS PRODUCT:

Sitecore will provide the following SaaS Product and entitlements:

Quantity	SaaS Product
1	Sitecore Experience Edge - XM (Corporate)

Entitlement	Entitlement Value
API Calls/Second	80
File Storage	Unlimited
Bandwidth	Unlimited

Permitted Usage. Permitted Usage has the same meaning as that governing Customer's use of the Sitecore Software.

HOSTED SERVICES:

Customer is entitled to the following in accordance with the description of the Hosted Services set forth in Exhibit A hereto:

Service Level	Annual Azure Spend (USD)
Managed Cloud Standard XM	$94,536.00

*This is the total annual average Azure Spend Commitment. Customer's actual Azure Spend is subject to change as set forth in Exhibit A.

Service Levels and Support

The Service Level Agreement for Sitecore Managed Cloud can be found at https://www.sitecore.com/trust/policies/service-level-agreements and the Application Support terms are available at https://kb.sitecore.net/articles/583182.

Sitecore Usage Policy

Customer's use of the Hosted Services is subject to Customer's compliance with the Sitecore Usage Policy available at https://www.sitecore.com/Trust/Policies/Usage-Policy.

Permitted Usage. "Permitted Usage" is given the meaning set forth in the Order for Software between the parties

Overages

Overages will be calculated annually, based on the cumulative Azure Spend in each consecutive 12-month period during a Subscription Term. If at any time during such 12-month period Customer's Azure Spend exceeds the Azure Spend Commitment for such 12-month period, then Sitecore shall invoice Customer the amount over the Azure Spend Commitment multiplied by 1.4 (and where the Azure Spend Commitment is exceeded prior to the end of such 12-month period, any additional overages will be invoiced monthly until the expiration of such 12-month period) (the "Support Rate"). Thus, for sake of clarity, Customer is subject to overage charges and invoicing based on the cumulative Azure Spend and Azure Spend Commitment over the relevant 12-month period, where the Support Rate consists of both the excess Azure Spend and the cost of the additional support. Customer shall provide a written notice contesting the accuracy of any overage charges invoiced herein within ten (10) days of the date of the invoice or the invoice will otherwise be deemed accurate and accepted by Customer.

*For every dollar (USD) over the Azure Spend Commitment, Sitecore will bill Customer that overage amount multiplied by the Support Rate

Configuration Detail for Hosted Services

Configuration Detail is as set forth online here https://kb.sitecore.net/articles/003519.*

*Configuration Detail is subject to change over time due to changes in the underlying technology used by, or pricing of, those third party Sitecore vendors that are used to provide the Hosted Services. Sitecore will use every reasonable effort to limit any impact to the Hosted Services because of a change in Configuration Detail. Should such a change result in a material decrease in functionality of the Hosted Services, then in addition to Customer's other termination rights under the Master Terms, where such change occurs during Customer's Subscription Term, Customer may terminate this Order upon written notice to Sitecore. In the event of such termination, Sitecore will refund a pro-rata portion of any pre-paid fees applicable to the Subscription Term.

Additional Procurement for Hosted Services

By providing notice to Sitecore, Customer may at any time request pricing for any additional procurement that would result in an increase in Customer's Azure Spend Commitment, or for additional Add-On Premium Services (if applicable). If then ordered by Customer, the cost for such additional procurement will be added to Customer's annual subscription fees and Customer will be invoiced (i) in the case of increases in the Azure Spend Commitment, the full amount, and (ii) in the case of Add-On Premium Services, a pro-rata amount applicable to the remaining months in the current invoicing cycle. For sake of clarity, additional procurement under Exhibit A (i.e. which may result in an increase in Customer's Azure Spend, but not Customer's Azure Spend Commitment) does not require a mutually signed add-on order.

2. Consulting & Training

Essentials Training

All users defined in the Usage Policy will have 24 x 7 access to the Sitecore Essentials Subscription for the duration of the contract. Access includes foundational training on Sitecore products and services. Content is available to both new and existing users, and includes:

- ~25 hours of total learning time
- Free, on-demand access with an account, available here: https://learning.sitecore.com/registration
- Knowledge checks and quizzes

One-Time Services

Sitecore will provide the following Consulting Services. Consulting Services descriptions are located at: https://www.sitecore.com/legal/consulting-packages:

Quantity	Description
1	Architect Assistance

3. Custom Consulting Services

Available upon request.

4. Support and SLA

Quantity	Description
1	Sitecore Standard Support (XM-Corporate)

Support terms can be found at https://kb.sitecore.net/articles/583182.
The applicable SLA for SaaS Product(s) or Hosted Services, respectively, can be found at https://www.sitecore.com/trust/policies/service-level-agreements.

5. Sitecore360

Quantity	Description
1	Sitecore360 Bundle

Entitlement	Entitlement Value	Entitlement Type
Sitecore360 Expert Services	4	Hours Per Month
Sitecore360 Premier Assure Services	12	Activity Points Per Year
Sitecore360 Professional Plus Training	4	End Users
Sitecore Premium Support	Included	N/A

A description of the Sitecore360 entitlements can be found at: https://www.sitecore.com/legal/sitecore360.

6. Subscription Term; Renewal

This Order is effective on the Order Effective Date and continues for the minimum commitment of **24** months, unless earlier terminated under the Agreement. At the end of this minimum commitment, Customer may renew for additional terms, as set forth below, by providing Sitecore with at least 90 days' written notice of its intent to renew prior to the next renewal date. The "Subscription Term'" is equal to the minimum commitment plus any renewals, which will be either:

☐ additional 12-month renewal terms with an annual increase in pricing of 9%; or

☒ additional 36-month renewal terms with an annual increase in pricing of 5%.

7. Invoicing

Below is a summary of the invoicing under this Order:

Year 1

Product Type	Net Annual Price
One-Time Fee	10,000.00 USD
Recurring Fee	148,634.40 USD*

*Special Azure Promotion
Customer's first invoice reflects a promotional Azure discount equal to USD 15,842 of Azure Spend. This discount is contingent on this Order being signed by Customer by December 20th, 2022, and Sitecore receiving notice that Customer is ready to receive the Azure Sets described in Section 1: Hosted Services above by January 20th, 2023 (collectively, the "Conditions"). In the event the Conditions are not met, Sitecore will invoice Customer an additional USD 15,842.

Year 2

Product Type	Net Annual Price
Recurring Fee	169,229.46 USD

Initial Invoice will be sent to Accounts Payable at accountspayable@caloptima.org. Sitecore will credit Customer's first invoice for any unused maintenance fees paid to Sitecore under the Former License, calculated on a daily basis from the Order Effective Date to the expiration of the current maintenance period.

If applicable, any Recurring fees under this Order will be invoiced annually and due on the anniversary of the Order effective date, for the remainder of the Subscription Term.

8. Payment Terms

All prices as set out in this Order are USD and exclusive of any applicable taxes unless otherwise indicated. Payment terms for all amounts under this Order are **Net 90 days** from the date of a valid, undisputed invoice issued by Sitecore. Customer agrees to pay interest on undisputed invoices calculated at the rate of one percent (1%) per month or the maximum amount permitted by law, whichever is less, of the total outstanding amount, for the time period the payment remains past due. Customer also agrees to pay Sitecore all reasonable expenses incurred by Sitecore in exercising any of its rights under this Order or applicable law with respect to a payment default, including but not limited to reasonable attorneys' fees and the fees of a collection agency retained by Sitecore. An invoice

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shall be valid where the amounts invoiced and Software and/or Services are accurate and without regard to other referenced information including but not limited to purchase order number.

9. Additional Definitions

Definitions:

The additional definitions applicable to this Order can be found at: https://www.sitecore.com/legal/order-definitions

Sitecore Experience Edge Definitions:

"API Call" means any http request to the API / endpoint of the main application (excluding requests made to Satellites), where Satellite means an additional location, separate from the central Instance, used to provide optimized upload or download capabilities for additional geographical locations.

"Experience Edge API" is a read-only API for delivering published content from Sitecore Software for direct use in digital touchpoints, point-of-sale kiosks, websites and other distribution channels. Content is accessible through a GraphQL API.

"Experience Edge API Call" is defined as an API Call, including any GraphQL query, to the Experience Edge API that is not already cached in the CDN. Cached queries are not considered API Calls and are not rate limited.

"Entities" means uniquely identifiable pieces of content managed within Sitecore Content Hub or one of the Sitecore Software products. Each image, video, audio file, PDF, newsletter, blog, page, contact, and document version is a separate Entity. If individual content elements are stored separately, like a header, title, or body paragraph, each of these is also an Entity. In the Sitecore Software, each template, layout or other data structure would also be an Entity. In addition, if Sitecore Content Hub is used to store product content, each element of the product hierarchy (e.g. brand, family, product, SKU) is an Entity.

"Published Entities" means all Entities made available through GraphQL APIs for delivery or publication by Sitecore Experience Edge.

"Experience Edge Storage" is defined as data storage used for the hosting of published entities, such as media files and pre-rendered layout elements, in the Sitecore Experience Edge platform from the Sitecore Software.

"Experience Edge Bandwidth" is defined as data transfer of entities from the Sitecore Experience Edge CDN, including any GraphQL query or media file regardless of if the object is cached in the CDN.

By executing this Order, Customer commits to the payments set forth above. Each person signing this Order represents and warrants that he or she has been duly authorized and has full authority to execute this Order on behalf of the party below. This Order may be executed in counterpart, and may be executed by way of facsimile or electronic signature, and if so, will be considered an original.

Sitecore	**CalOptima**
By: DocuSigned by: Mike Fenn 8C3A1C87F2194F9...	By: DocuSigned by: Michael Hunn EDDDDCC19C894FB...
Print Name: Mike Fenn	Print Name: Michael Hunn
Title: President Americas	Title: CEO
Date: 21 December 2022	Date: 12/20/2022

Exhibit A – Hosted Services Description

The Hosted Services Description provided below is agreed upon as of the Order Effective Date and is given for purposes of informing the relevant pricing and Azure Spend Commitment.

The performance rating sizes per Tier Size were determined by performance testing a simple marketing site and finding the smallest resource sizes required to hit the associated Visits per month. The simple marketing site was mainly read-only, with no login activity and few xDB interactions. Dependent requests were not tested (e.g., images, JS, and CSS) and it is assumed these assets will be served by a CDN or similar function. Thus, the specified sizing serves as a starting point to estimate the Azure requirements for the Customer solution. Customers may need to adjust some or all of the sizes or instance counts upon performance testing the final solution with solution code and customizations.

Customer acknowledges that following the Order Effective Date, Customer may choose, at its sole discretion, to make changes to the below, which changes may affect Customer's actual Azure Spend. Furthermore, Customer acknowledges that following deployment of the Hosted Services, Customer's actual Azure Spend is subject to change.

Hosted Services Selection:

Topology Description	Number of Sets	Tier	Size	Azure Data Center*	Deployment Environment Type	Deployment Version	Solr Search Option	DR Type
Production	1	xM Standard	Small	West US	App Service	10.2	Yes	Basic_Cold
Non-Production	1	xM Standard	xSmall	West US	App Service	10.2	Yes	None
Non-Production	1	xM Standard	xSmall	West US	App Service	10.2	Yes	None
Non-Production	1	xM Standard	xSmall	West US	App Service	10.2	Yes	None
							Total Azure Spend Cap (per month) in USD	**7,878 USD**

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Master Subscription Terms and Conditions

These master subscription terms and conditions ("**Master Terms**") are entered into as of the date of the last party to sign below ("**Effective Date**") between **Sitecore USA, Inc.** ("**Sitecore**"), with offices at **101 California St, Suite 1600, San Francisco, CA, USA, 94111,** and **Orange County Health Authority, a public agency dba CalOptima Health** ("**Customer**"), with offices at **505 City Parkway West, Orange, CA, USA, 92868**. Unless otherwise defined below, capitalized terms will have the meaning given to them in the last section of these Master Terms.

1) **FRAMEWORK.** These Master Terms, together with the Data Processing Addendum and all incorporated Orders, constitute the "**Agreement**." An "**Order**" consists of an order for one or more Sitecore Products and Services which is separately executed by Sitecore and Customer on or after the Effective Date and which states its intention to be governed by these Master Terms. An Order may incorporate attachments or exhibits that contain additional information relevant to a particular Sitecore Product or Service. Affiliates of the parties may agree to operate under these Master Terms, and in such event, the Affiliates may enter into an Order and agree to be bound by these Master Terms.

2) **PRICING, INVOICING AND EXPENSES.** The relevant fees and payment terms will be set forth in the applicable Order. Customer will only reimburse Sitecore for travel and accommodation if pre-authorized by Customer and travel and accommodation complies with Customer's Travel Policy (G.A.5004) attached as Exhibit E.

3) **TAXES.** Customer will be responsible for sales, use, value-added tax, and excise taxes and any like charges required to be collected by Sitecore with respect to the Sitecore Products and Services provided by Sitecore, and Sitecore will list those taxes and charges as separate line items on Sitecore's invoice. Sitecore will be responsible for all taxes related to its Personnel or business operations, including taxes based on the net income of Sitecore and any taxes payable upon the payroll of Sitecore Personnel. If Customer is exempt from transaction taxes, Customer will provide Sitecore with evidence of such tax-exempt status prior to entering into any Order.

4) **SOFTWARE LICENSES AND RESTRICTIONS**

   a) Customer may request Sitecore to provide a license to Software, and if agreed upon such Software will be documented in an Order. The terms of this Section 4 will apply to such Order except to the extent explicitly overridden in such Order. Additionally, such Order may set forth other specific license terms and restrictions applicable to the Software being licensed to Customer. All licenses are limited to use by the Customer or Customer Affiliate executing the Order unless the applicable Order specifically states otherwise.

   b) Sitecore and its licensors retain all right, title and interest in the Software and Documentation, except as provided otherwise in this Section 4. Subject to compliance with the Agreement, Sitecore grants Customer a non-exclusive, non-transferable, non-assignable, non-sublicensable license, solely during the Subscription Term, to copy and use the Documentation, and the Software in supported configurations as described in the Documentation, in compliance with applicable laws, solely for the Permitted Usage.

   c) Upon execution of an Order including Software, Customer will be provided a license key that gives Customer access to the Software ("**License Key**"). The License Key will be time-limited until full payment of the applicable fees have been received by Sitecore.

5) **HOSTED SERVICES.** Customer may request Sitecore to provide Hosted Services, and if agreed upon such Hosted Services will be documented in an Order. Additionally, such Order may set forth other specific terms and restrictions applicable to the Hosted Services. Sitecore and its licensors retain all right, title and interest in the Hosted Services, Sitecore Technology and applicable Documentation, except as provided otherwise in this Section 5. Subject to compliance with the Agreement, Sitecore grants Customer a non-exclusive, non-transferable, non-assignable, non-sublicensable license to use the Sitecore Technology and access the Hosted Services, solely during Customer's applicable Subscription Term and solely for the Permitted Usage. Customer's use of the Hosted Services is subject to compliance with the Sitecore Usage Policy, as applicable to the services purchased by Customer.

6) **SAAS PRODUCTS.** Customer may request Sitecore to provide SaaS Products, and if agreed upon such SaaS Products will be documented in an Order. Sitecore and its licensors retain all right, title and interest in the SaaS Products and any applicable Documentation, except as provided otherwise in this Section 6. Subject to compliance with the Agreement, Sitecore grants Customer a non-exclusive, non-transferable, non-assignable, non-sublicensable license to access the SaaS Products, solely during Customer's applicable Subscription Term, and solely for the Permitted Usage. Customer's use of the SaaS Products is subject to compliance with the Sitecore Usage Policy.

7) **SUPPORT & MAINTENANCE; SERVICE LEVEL AGREEMENT.** Sitecore will provide support and maintenance services during each applicable Subscription Term in accordance with the terms of the applicable Order. Sitecore offers a Service Level Agreement for each of its SaaS Products and Hosted Services, the details of which will be included as part of each applicable Order.

8) **CONSULTING SERVICES; DELIVERABLES.** Customer may request Sitecore to provide Consulting Services for its employees or Authorized Third Parties, and if agreed upon such Consulting Services will be documented in an Order. Except as provided otherwise in this Section 8, Customer retains all right, title and interest in the Customer Materials, and Sitecore may only use the Customer Materials for performance of the Consulting Services. Sitecore retains all right, title and interest in the Deliverables. Subject to compliance with this Agreement, Sitecore grants Customer a non-exclusive, non-transferable, non-assignable, non-sublicensable, perpetual license to copy, use and modify any Deliverables provided by Sitecore solely for Customer's internal business purposes.

9) **TRAINING SERVICES**

   a) Customer may request Sitecore to provide Training Services for its employees or Authorized Third Parties, and if agreed upon such Training Services will be documented in an Order. Such Training Services may consist of participating in publicly available classes, scheduling Customer-specific training, or subscribing to eLearning classes.

   b) Subject to compliance with this Agreement, Sitecore grants Customer a non-exclusive, non-transferable, non-assignable, non-sublicensable, perpetual license to copy and use any Training Materials provided by Sitecore solely for Customer's internal business purposes. Unless pre-approved in writing by Sitecore, Customer is prohibited from (i) audio recording, editing, reproducing, broadcasting, live-streaming or otherwise making available, in whole or in part, the Training Services or any Training Materials to third parties, and (ii) providing any third party with access to the name, voice, image, or likeness of the Sitecore training Personnel.

   c) Training Services are prepaid and, unless otherwise set forth in an Order, must be consumed within 12 months of the Order effective date, after which date any remaining credits will otherwise expire. Sitecore will not pay any refund for expired Training Services.

10) **AUTHORIZED THIRD PARTIES; RESTRICTIONS ON USE**

a) Customer may permit Authorized Third Parties to assist Customer in the implementation and use of the Sitecore Products and Hosted Services provided that: (i) such activities are within the scope of the activities Customer is itself authorized to perform under the Agreement; (ii) such Authorized Third Parties' acts are primarily for the direct or indirect benefit of Customer; and (iii) such Authorized Third Parties are not charged a fee by Customer for such activities. Customer is prohibited from using the Sitecore Products and Hosted Services in any time-sharing or other commercial arrangement of any kind that makes the Sitecore Products and Hosted Services available to third parties for the third party's own benefit. Except as expressly stated in the Agreement, no third party has any rights under the Agreement. Customer is fully liable for compliance with the Agreement by its Authorized Third Parties.

b) Except as specifically authorized under the Agreement, by applicable law or by Sitecore in writing, Customer will not (i) modify, disclose, disassemble, decompress, reverse compile, reverse assemble, reverse engineer, or translate the Sitecore Products, Services or Documentation, (ii) rent, lease, lend, distribute, sell, assign, license, or otherwise transfer the Sitecore Products, Services, Documentation or any portion thereof, or (iii) create any derivative works of the Sitecore Products, Services or Documentation.

11) **PERSONNEL**

a) Sitecore performs standard background checks on all newly hired employees, which include: (i) verification of education and previous employment, (ii) right to work in the applicable jurisdiction, and (iii) checks against applicable criminal databases where available and permitted by local law. Sitecore also requires all of its employees to comply with its Code of Business Conduct. In addition, Sitecore trains all of its employees on the proper treatment of confidential information and information security best practices in accordance with industry standards and any applicable governmental agency requirements.

b) Sitecore is an independent contractor and is responsible for all matters governing the employment of Personnel. Sitecore will be responsible for the supervision, direction, and control of its Personnel, as well as the payment of compensation and any other legally required benefits. In no event will Personnel be deemed an employee, subcontractor, representative, or agent of Customer.

c) SUBCONTRACTORS. Sitecore may not subcontract or delegate its obligations or the performance of services under this Agreement without Customer's prior written consent, which Customer may exercise in its reasonable discretion. If Sitecore lists subcontractors in an Order, Customer's execution of that order shall constitute consent under this section. The restrictions in this Section 11)c) do not apply to Subprocessors as described in the Data Processing Addendum or services performed by Sitecore's Affiliates.

12) **WARRANTIES.** Sitecore represents and warrants that:

a) it is duly organized, validly existing, and in good standing under the laws of the jurisdiction of its incorporation or organization, and that it has all requisite power and authority to carry out its obligations described in the Agreement;

b) it will render the support and maintenance and the Services in a professional and workmanlike manner in accordance with industry standards using qualified Personnel with the necessary skills, qualifications and experience;

c) the Software provided to Customer under an Order will comply with the Documentation for a period of 90 days following the effective date of the applicable Order ("**Limited Warranty Period**"). In the event any such Software does not operate according to the Documentation during this Limited Warranty Period, Sitecore will repair or replace the Software. If Sitecore is unable to repair or replace the Software within 30 days of receiving notice of the defect, Customer will have the right to terminate the applicable Order and receive a full refund of the fees paid for the Software under that Order, and such refund will be Customer's sole and exclusive remedy under this warranty;

d) before delivery to Customer the Software has been tested by software generally used in the industry for such purposes to determine that the Software is free from viruses and other malicious code;

e) the SaaS Products made available to Customer under an Order will materially perform in accordance with the Documentation during the applicable Subscription Term;

f) the provision of the Services will not violate any applicable laws, rules, regulations, and ordinances of any governmental body (collectively, "**Applicable Laws**"); and

g) its Personnel will comply with all Applicable Laws and all obligations under the Agreement in performing the Services.

h) to the best of its knowledge, neither Sitecore nor any of its Personnel are suspended or excluded from any federal or state health care program as of the Effective Date.

13) **DISCLAIMER OF WARRANTIES. EXCEPT AS EXPRESSLY SET FORTH IN SECTION 12 ABOVE OR TO THE EXTENT ANY WARRANTIES IMPLIED BY LAW CANNOT BE WAIVED, SITECORE MAKES NO WARRANTY OF ANY KIND, WHETHER EXPRESS OR IMPLIED, STATUTORY OR OTHERWISE. SITECORE EXPRESSLY DISCLAIMS ALL IMPLIED WARRANTIES, INCLUDING BUT NOT LIMITED TO ANY IMPLIED WARRANTIES OF MERCHANTABILITY, NON-INFRINGEMENT, FITNESS FOR A PARTICULAR PURPOSE OR ANY WARRANTIES ARISING FROM COURSE OF DEALING. SITECORE ALSO EXPRESSLY DISCLAIMS ANY AND ALL EXPRESS, IMPLIED OR STATUTORY WARRANTIES THAT THE SITECORE PRODUCTS AND SERVICES WILL MEET CUSTOMER'S REQUIREMENTS, OR THAT THE OPERATION OF THE SITECORE PRODUCTS OR SERVICES WILL BE UNINTERRUPTED OR ERROR FREE.**

14) **CONFIDENTIAL INFORMATION.**

a) The term "**Confidential Information**" means all information disclosed in written, oral, electronic, visual or other form by either party (each a "**Disclosing Party**") to the other party ("**Recipient**") and either (a) marked or designated as "confidential" or "proprietary" at the time of disclosure or (b) disclosed in circumstances under which a reasonable person would understand it is to be treated as confidential, including business plans, partnership and other contractual arrangements, and licensing plans. Confidential Information does not include information that (i) is or becomes a matter of public knowledge through no fault of the Recipient, (ii) was rightfully in the Recipient's possession free of any obligation of confidence, (iii) was rightfully disclosed to Recipient by a third party without restriction as to use or disclosure, provided the third party's disclosure did not violate any other agreement, or (iv) is independently developed by Recipient without use of or reference to Disclosing Party's Confidential Information and does not violate any Applicable Law or other agreement. Recipient will hold the Confidential Information received from the Disclosing Party in confidence and will not, directly or indirectly, disclose it to any other person or entity except to Recipient's and its Affiliates' employees and independent

contractors who have (x) a need to know, (y) been notified that such information is Confidential Information, and (z) entered into binding confidentiality obligations no less protective of the Disclosing Party than the Agreement. Recipient will protect the Disclosing Party's Confidential Information by using the same degree of care as Recipient uses to protect its own confidential or proprietary information of a like nature (but not less than a reasonable degree of care). Recipient will promptly notify the Disclosing Party upon learning of any misappropriation or misuse of Confidential Information disclosed hereunder. Notwithstanding the foregoing, Recipient will be permitted to disclose Confidential Information pursuant to any statutory or regulatory authority or court order, including as provided in Section 15(b) below, provided that Recipient provides the Disclosing Party prompt prior notice (to the extent legally permitted to do so), and the scope of such disclosure is limited to the extent possible.

b) California Public Records Act. As a local public agency, Customer is subject to the California Public Records Act (California Government Code Sections 6250 *et seq.*) (the "PRA"). Sitecore hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless exempt from disclosure under the provisions of the PRA. Customer may be required to reveal certain information pursuant to the PRA believed to be proprietary or confidential by Sitecore.

15) **CUSTOMER DATA; USAGE DATA FEEDBACK.**

a) Customer owns and shall retain all right, title, and interest in and to the Customer Data. Customer represents and warrants that none of the Customer Data violates the Agreement and that it has all necessary right, title, interest and consent necessary to allow Sitecore to use Customer Data for the purposes of fulfilling its obligations under the Agreement. Customer understands and agrees that the Customer Data should not include any Restricted Data without Sitecore's prior written consent.

b) Sitecore will manage, process, and store all Customer Data in accordance with the Data Processing Addendum. Customer grants to Sitecore a non-exclusive and non-transferable right and license during the Subscription Term to copy, store, process, transmit, and otherwise use the Customer Data solely as necessary and appropriate for Sitecore to fulfil its obligations under the Agreement and in accordance with Applicable Laws. In addition, Sitecore may use aggregated Anonymized Data for the purpose of improving Sitecore Products and Services. As between the parties, Sitecore owns all right, title and interest in and to the Usage Data and Anonymized Data.

c) Customer understands and agrees that Sitecore will use the Usage Data (i) in order to provide the Sitecore Products and Services to Customer, and (ii) for its internal purposes to improve the Sitecore Products and Services, provided that any such use will not disclose the identity of Customer or its users.

d) Customer grants Sitecore a royalty-free, worldwide, transferable, sublicensable, irrevocable, perpetual license to use the Feedback for the development of Sitecore Products and Services, without restriction and without any compensation due to Customer.

16) **THIRD PARTY TECHNOLOGY.** Any implementation of Third Party Technology, including any exchange of data between the Third Party Technology and the Sitecore Products and Services, is the sole responsibility of Customer. Sitecore makes no warranties as to the Third Party Technology or its integration or compatibility with the Sitecore Products and Services, and Sitecore is not responsible for any disclosure, modification or deletion of Customer Data caused by the Third Party Technology.

17) **INSURANCE.** Sitecore will maintain in force during the Term adequate liability insurance to protect Sitecore from: (a) errors and omissions, commercial crime, and cyber liability related to the Software; (b) claims of personal injury, death, or property damage that arise from Sitecore's provision of Services; and (c) claims under workers' compensation where required by law. Such liability insurance will comply with the minimum amounts required by law. Upon request, Sitecore will provide Customer with a copy of the applicable certificates of insurance covering Sitecore and its business operations.

18) **TERM AND TERMINATION**

a) Term. These Master Terms will commence on the Effective Date and, unless earlier terminated in accordance with this Section, will continue as long as there is an active Order in place between the parties or any of their Affiliates (the "**Term**").

b) Termination for Breach. Either party may terminate these Master Terms and any active Order if the other party defaults in the performance of, or fails to perform, any of its material obligations under these Master Terms or any Order and fails to cure that default within 30 days following receipt of written notice from the non-breaching party. For purposes of clarity, a party may choose to terminate only the applicable Order if the breach event was limited to the substance of that Order. If either party terminates these Master Terms for breach, all active Orders will also terminate. In the event Sitecore terminates these Master Terms or any Order for Customer's breach, Customer is still obligated to pay any undisputed fees which have accrued prior to termination. In the event Customer terminates an Order for Sitecore's breach, Sitecore will refund the pro-rata share of any fees Customer has prepaid for the applicable Subscription Term under the Order.

c) Termination for Insolvency. Either party may terminate the Agreement by providing written notice to the other party if: (i) the other party files a voluntary petition in bankruptcy or an involuntary petition is filed against it; (ii) a trustee or receiver is appointed by a court for all or a substantial portion of the assets of the other party; (iii) the other party becomes insolvent, suspends business, or ceases to conduct its business in the ordinary course; or (iv) the other party makes an assignment of its assets for the benefit of its creditors.

d) Suspension. Sitecore reserves the right, by providing electronic notice to Customer, to suspend any Order for Hosted Services or SaaS Products in the event Sitecore reasonably believes that Customer has violated the Sitecore Usage Policy and such suspension is (i) deemed necessary to address an urgent situation or (ii) is required by an underlying service provider. Sitecore will provide as much advance notice as is reasonably practical. In the event Customer does not cure the situation giving rise to this suspension within 10 days of receipt of notice, Sitecore may terminate the Order for breach with no further right to cure.

e) Change in Law. Sitecore reserves the right, by providing at least 60 days' electronic notice to Customer, to terminate any Order for Hosted Services or SaaS Products in the event there is a change to the laws governing Sitecore's provision of the Hosted Services or SaaS Products which would cause Sitecore to violate such law by continuing to offer the Hosted Services or SaaS Products. In the event of a termination under this provision, Sitecore will use commercially reasonable efforts to limit the negative impact experienced by Customer by assisting with a transfer to comparable services, or such other action as Customer may reasonably request. In addition, Sitecore will refund the pro-rata share of any fees Customer has prepaid for the applicable Subscription Term under the applicable Order.

f) Immediate Termination. Customer may immediately terminate the Agreement or any Order upon written notice to Sitecore if a governmental agency with jurisdiction over Customer requires such termination due to (i) a change in law governing Customer's use of the Hosted Services or SaaS Products; or (ii) a violation of law by Sitecore.

g) Effect of Termination. Upon termination of any Order, the license and access rights applicable to such Order will also terminate, and Customer will immediately cease all use of the Sitecore Products provided to Customer under that Order and delete all copies of Software in its possession or control. Upon Sitecore's request Customer will then certify that such use has ceased and that the Software has been erased, destroyed or otherwise made inoperable by any user in the future. Upon termination of these Master Terms, those provisions of these Master Terms which by their nature are intended to survive will survive termination. With respect to any Order for Hosted Services or SaaS Products: (i) Sitecore will only retain the Customer Data stored in its systems for 30 days (the "Retrieval Period") after termination of any Order for Hosted Services or SaaS Products; (ii) Sitecore will assist with any reasonable request from Customer to retrieve the Customer Data within the Retrieval Period, provided that if the Order is terminated for Customer's breach, (A) such assistance will be provided at Customer's cost and (B) Customer acknowledges that Sitecore (acting reasonably) shall not be responsible where it is not able to assist as a result of the nature of Customer's breach; and (iii) if requested by Customer, Sitecore will destroy Customer Data before expiration of the Retrieval Period, provided Sitecore may retain Customer Data where required by Applicable Laws or reasonably necessary to prevent liability.

19) **LIMITATION OF LIABILITY. NEITHER PARTY WILL BE LIABLE FOR ANY INDIRECT, INCIDENTAL, SPECIAL, CONSEQUENTIAL, PUNITIVE, OR EXEMPLARY DAMAGES ARISING OUT OF OR RELATED TO THE AGREEMENT UNDER ANY LEGAL THEORY, EVEN IF THE PARTY HAS BEEN ADVISED OF, KNOWS OF, OR SHOULD HAVE KNOWN OF THE POSSIBILITY OF SUCH DAMAGES. NEITHER PARTY'S AGGREGATE LIABILITY WILL EXCEED TWO TIMES (2X) THE AMOUNT OF FEES PAID BY CUSTOMER FOR SITECORE PRODUCTS AND SERVICES UNDER THE APPLICABLE ORDER IN THE TWELVE MONTHS PRECEDING THE FIRST INCIDENT GIVING RISE TO THE LIABILITY. THE FOREGOING EXCLUSIONS AND LIMITS OF LIABILITY WILL NOT APPLY TO: (A) EITHER PARTY'S INDEMNIFICATION OBLIGATIONS UNDER THE AGREEMENT; (B) CUSTOMER'S VIOLATION OF THE SITECORE USAGE POLICY; AND (C) CUSTOMER'S BREACH OF THE LICENSES OR ACCESS RIGHTS GRANTED BY SITECORE IN SECTIONS 4, 5, 6, 8, 9 AND 10 OF THIS AGREEMENT. FURTHERMORE, NOTHING HEREIN WILL LIMIT A PARTY'S LIABILITY FOR THAT PARTY'S INTENTIONAL MISCONDUCT, GROSS NEGLIGENCE, OR FRAUD, OR ANYTHING ELSE THAT MAY NOT BY LAW BE LIMITED OR EXCLUDED.**

20) **ASSIGNMENT**. Neither party may assign the Agreement, by operation of law or otherwise, except with the other party's written consent, which will not be unreasonably withheld or delayed, except that either party may assign the Agreement to a successor (whether by merger, sale of assets, sale of stock, or otherwise) or an Affiliate that agrees to assume that party's obligations under the Agreement, upon providing reasonable notice to the other party of such assignment. Any attempted assignment or transfer in violation of this Section will be void and of no force or effect.

21) **WAIVERS**. All waivers must be in writing and signed by authorized representatives of the parties. Any waiver or failure to enforce any provision of the Agreement on one occasion will not be deemed a waiver of any other provision or of such provision on any other occasion.

22) **SEVERABILITY**. If any provision of the Agreement is adjudicated to be unenforceable, such provision will be deemed changed and interpreted to accomplish the objectives of such provision to the greatest extent possible under applicable law and the remaining provisions will continue in full force and effect.

23) **AUDIT RIGHTS & LICENSE VERIFICATION**. With respect to an Order including Software, Customer will maintain accurate records of its compliance with the Agreement and the Order during the Subscription Term, and will promptly provide these records to Sitecore upon its request. Sitecore may only request these records once in any 12-month period. If the records are not timely produced, or if Sitecore has reasonable grounds to question their accuracy, Sitecore may, at its own expense, engage an independent auditor to audit Customer's use of the Software. Any such audit will be conducted upon reasonable notice to Customer and during Customer's normal business hours using an auditor reasonable acceptable to Customer. Customer will reasonably cooperate with efforts to conduct the audit, including providing the auditor, in a timely fashion, all relevant information regarding its compliance with the Agreement. If such audit determines any unauthorized use of the Software, Sitecore will invoice Customer for all such unauthorized use in accordance with Sitecore's then-current retail prices computed from the date the excess usage commenced. If this invoice exceeds 5% of the amount of fees paid or payable under the applicable Order including Software for the most recent three years, Customer also agrees to pay the expense and costs of the audit. Customer will pay all invoices described in this section within 30 days from receipt. In addition, Customer understands that the Software may track and report to Sitecore the License Key ID, Customer name, hostname (Customer's website URL), host IP, version, and other usage information regarding the Software.

24) **NOTICES**. Each party will send notices to the other party at its address stated at the beginning of this Agreement or at an address specified by the receiving party in writing, attention Legal Department. Email notices to Sitecore may be sent to legalnotice@sitecore.com. All notices sent under the Agreement will be in writing, properly addressed, and: (a) mailed by first-class or express mail, or certified mail, as applicable, receipt requested; (b) sent by reputable overnight delivery service; (c) sent via email; or (d) personally delivered to the receiving party. Each notice will be deemed given upon receipt of that notice by the other party.

25) **FORCE MAJEURE**. Except for any payment obligations under the Agreement, neither party will be in default or otherwise liable for any delay or failure to perform if such delay or failure arises by any event beyond its reasonable control, including, but not limited to, work stoppages, acts of war or terrorism, civil or military disturbances, or nuclear or natural catastrophes; provided the non-performing party provides prompt notice to the other party, and such failure or delay could not have been prevented by reasonable precautions. In such event, the non-performing or delayed party will be excused from further performance for as long as such circumstances prevail and such non-performing or delayed party continues to use its best efforts to recommence performance or observance whenever and to whatever extent possible without delay. In the event one party's lack of performance under this provision continues for more than 30 days, the other party may terminate this Agreement without any liability to the other party related to the termination.

26) **COMPLIANCE WITH LAWS**. In performing its obligations under the Agreement, each party must comply with all Applicable Laws, including as set forth in the Data Processing Addendum and Exhibit A, Exhibit B, Exhibit C, and Exhibit D, which are all attached to this Agreement and incorporated into the Agreement by this reference.

27) **GOVERNING LAW AND VENUE.** The validity, construction, interpretation, and performance of the Agreement shall be governed by and construed in accordance with the laws of the State of California except as to its principles of conflicts of laws. The parties hereby (a) submit to the exclusive jurisdiction of the state and federal courts located in California, and (b) irrevocably waive, and agree not to assert by way of motion, defense, or otherwise, in any such action, any claim that it is not

subject personally to the jurisdiction of the above-named courts, that its property is exempt or immune from attachment or execution, that the action is brought in an inconvenient forum, that the venue of the action is improper, or that the Agreement may not be enforced in or by any of the above-named courts.

28) **INDEMNITY**

a) Sitecore will defend, indemnify and hold harmless Customer and its respective directors, officers, employees, and agents (the "**Customer Indemnitees**"), from and against any third party claims, losses, damages, suits, fees, judgments, costs and expenses (collectively referred to as "**Customer Claims**"), including reasonable attorneys' fees incurred in responding to such Customer Claims, that the Customer Indemnitees incur as a result of (i) a claim that any Sitecore Product, Services, Training Material or Deliverable (collectively "Indemnified Products") infringes or violates any third party intellectual property right, or (ii) any personal injury (including death) or damage to tangible property resulting from Sitecore or its Personnel's acts or omissions, or (iii) Sitecore's intentional misconduct. Notwithstanding the foregoing, the following shall apply in respect of any Customer Claims:

i) Sitecore will have no obligation or liability for that portion of any Customer Claims of infringement arising out of or in connection with: (i) use of a superseded version of the Software if the infringement would have been avoided by the use of an updated release of such Software provided that Sitecore has notified Customer that such current version release would rectify such infringement and Customer has been provided with a reasonable amount of time to install such new version; (ii) the combination, operation or use of the Indemnified Product with any software, hardware or other materials not furnished by or on behalf of Sitecore; (iii) any modification of the Indemnified Product not performed by or on behalf of Sitecore; or (iv) any breach by Customer of this Agreement, if the infringement would have been avoided by Customer not breaching the Agreement.

ii) If Sitecore reasonably believes Customer's use of an Indemnified Product may be endangered or disrupted, Sitecore may: (i) modify the Indemnified Product so as to provide Customer with a functionally equivalent and non-infringing product; (ii) obtain a license or access rights for Customer to continue use of the Indemnified Product for the Subscription Term at no additional cost to Customer; or (iii) if Sitecore in its sole discretion determines that neither of the foregoing alternatives is commercially reasonable, then Sitecore may at its option terminate this Agreement or the applicable Order and promptly refund the pro rata portion of the fees paid by Customer for the applicable Indemnified Product for the applicable Subscription Term; and

iii) to the maximum extent permitted by applicable law, this Section states Sitecore's entire liability and Customer's exclusive remedy for claims of intellectual property infringement.

b) Customer will defend, indemnify and hold harmless Sitecore and its respective directors, officers, employees, and agents (the "**Sitecore Indemnitees**"), from and against any third party claims, losses, damages, suits, fees, judgments, costs and expenses (collectively referred to as "**Sitecore Claims**"), including reasonable attorneys' fees incurred in responding to such Sitecore Claims, that the Sitecore Indemnitees incur as a result of (i) Customer's collection, use or storage of Customer Data, including any claim that the Customer Data is Restricted Data, that violates Applicable Laws, or (ii) conduct that, if true, would constitute Customer's breach of the Sitecore Usage Policy.

c) A "**Covered Claim**" means a Customer Claim or Sitecore Claim, as applicable. With respect to a Covered Claim, the indemnified party must (i) provide reasonably prompt written notice of any Covered Claim to the indemnifying party, (ii) allow the indemnifying party to assume complete control of the defense or settlement of any Covered Claim, and (iii) provide reasonable cooperation and assistance. The indemnified party may participate at its own expense using counsel of its choice. The indemnified party's failure to perform any obligations under this paragraph (c) will not relieve the indemnifying party of its obligations under this Section unless the indemnifying party can demonstrate that it has been materially prejudiced as a result of such failure. Furthermore, the indemnifying party may not settle any Covered Claim without the indemnified party's prior written consent (which such consent shall not be unreasonably withheld, conditioned or delayed) if such settlement (i) contains a stipulation to or an admission or acknowledgement of any liability or wrongdoing on the part of the indemnified party, or (ii) imposes any obligation or liability upon the indemnified party.

29) **ENTIRE AGREEMENT; ORDER OF PRECEDENCE.** The Agreement constitutes the entire agreement between the parties regarding the subject matter hereof and supersedes all prior or contemporaneous agreements, understandings and communications, whether written or oral. In the event of conflict, the Agreement documents will have the following order of precedence: first the Data Processing Addendum, second these Master Terms, and then the applicable Order. Specific exceptions to these Master Terms or the Data Processing Addendum may be agreed upon in writing by Customer and Sitecore under a particular Order by specifically referencing the language that the parties agree to override. Exceptions will apply only for the Order in which they are included and will not amend, cancel, or waive any provision of these Master Terms for any other Order. The Agreement may be amended only by a written document signed by both parties specifically noting its intent to amend. Any additional terms or conditions contained in any purchase orders, acknowledgments, invoices, click-through license agreements or other documents delivered, provided, or made available in connection with the Agreement will be of no force and effect.

30) **DISPUTE RESOLUTION**

a) Meet and Confer. If either party has a dispute arising under or related to this Agreement, the parties shall informally meet and confer to try and resolve the dispute. The parties shall meet and confer within thirty (30) days of a written request submitted by either party in an effort to settle any dispute. At each meet-and-confer meeting, each party shall be represented by persons with final authority to settle the dispute.

b) Waiver of Jury Trial. Each party irrevocably waives, to the fullest extent permitted by Applicable Law, any and all right to trial by jury in any legal proceeding arising out of or relating to the Agreement.

31) **DEFINITIONS.** Terms defined below but not used in these Master Terms may be used in an Order.

a) "**Affiliate**" means any person or entity directly or indirectly controlled by or under common control with a party as of or after the Effective Date for so long as that relationship is in effect (including Affiliates subsequently established by acquisition, merger or otherwise).

b) "**Anonymized Data**" means Customer Data that is de-identified such that no person or entity (including but not limited to Customer) can be identified using commercially reasonable technology.

c) "**Authorized Third Parties**" means any subcontractors, agents or other third parties authorized by Customer to perform services related to the Sitecore Products on behalf of Customer.

d) "**Consulting Services**" means the professional consulting services provided by Sitecore under an Order, whether provided remotely or onsite at Customer facilities.

e) "**Customer Data**" means any data, content, materials, video, graphics, recordings, or text, including Personal Data, provided to Sitecore by Customer, Customer's Authorized Third Parties, or Customer's customers through use of the SaaS Products or Hosted Services.

f) "**Customer Materials**" means any documents, software, technical information or other materials made available by Customer for Sitecore's use in performing the Consulting Services.

g) "**Data Processing Addendum**" means the Sitecore data processing addendum available at https://www.sitecore.com/trust/dpa as of the Effective Date.

h) "**Deliverables**" means any document, report, code or other tangible development work provided by Sitecore to Customer as part of the Consulting Services under an Order, exclusive of any Customer Materials.

i) "**Documentation**" means the resources made available setting forth the then-current functional, operational, and performance capabilities of, and the required configurations and specification for acceptable use of, the Sitecore Products and Hosted Services, including as set forth on http://doc.sitecore.net, and with respect to the Content Hub SaaS Product, the usage guides and documentation as set forth on https://docs.stylelabs.com/.

j) "**Feedback**" means any ideas, proposals, improvements and other suggestions about the Sitecore Products or Services that Customer may choose to provide to Sitecore.

k) "**Hosted Services**" means the platform-as-a-service, infrastructure-as-a-service, email delivery services, or other cloud hosting services specified in an Order and provided by Sitecore, including any Sitecore Technology made available to Customer as part of the Hosted Services.

l) "**Permitted Usage**" will have the meaning set forth in the applicable Order. If no Permitted Usage is specified in the Order, "Permitted Usage" means management of Customer's own current and future public-facing web properties.

m) **"Personal Data"** means any information relating to an identified or identifiable natural person, or as otherwise defined under applicable law, but expressly excluding Restricted Data.

n) "**Personnel**" means Sitecore's employees, officers, and subcontractors.

o) "**Restricted Data**" means financial records, credit card data, personal health information, and any other data requiring a standard of protection greater than that set forth in the Data Processing Addendum.

p) "**SaaS Products**" means any software-as-a-service products specified in an Order and provided by Sitecore, including any Sitecore Technology made available to Customer as part of the SaaS Products.

q) "**Services**" means any Consulting Services, Training Services or Hosted Services that Sitecore performs or provides under the Agreement.

r) **"Sitecore Products"** means the Software and SaaS Products.

s) "**Sitecore Technology**" means any software, hardware, processes, user interfaces, algorithms and other technology used by Sitecore to provide the Hosted Services or SaaS Products.

t) "**Software**" means any of Sitecore's proprietary software products specified in an Order, including any patches, updates or upgrades provided by Sitecore.

u) "**Subscription Term**" means the term of Customer's license to use and/or access the Software, Services, or SaaS Products, as further described and defined in the applicable Order.

v) "**Third Party Technology**" means any third party applications or services provided by Customer or a third party for integration or use with Sitecore Products and Services.

w) "**Training Materials**" means any document, report, assessment, code, audio, video, simulation, or product information provided by Sitecore as part of the Training Services.

x) "**Training Services**" means the professional training services provided by Sitecore to Customer under an Order, including remote training, web-based training, and onsite classes.

y) "**Sitecore Usage Policy**" means the restrictions and limitations applicable to relevant Hosted Services or SaaS Products, which is available at https://www.sitecore.com/trust/policies/usage-policy.

z) "**Usage Data**" means any data collected by Sitecore, or to which Sitecore has access under this Agreement, as a result of Customer's use of the Sitecore Products and Hosted Services, but excluding Customer Data.

This Agreement may be executed in counterpart, and may be executed by way of facsimile or electronic signature, and if so, will be considered an original. Each person signing this Agreement represents and warrants that he or she has been duly authorized and has full authority to execute this Agreement on behalf of the party below.

Sitecore

By: DocuSigned by: Mike Fenn 8C3A1C87E2194F9...

Print Name: Mike Fenn

Title: President Americas

Date: 21 December 2022

CalOptima

By: DocuSigned by: Michael Hunn EDDDDCC19C894FB...

Print Name: Michael Hunn

Title: CEO

Date: 12/20/2022

EXHIBIT A
Regulatory Requirements

Customer is a public agency and is licensed by the California Department of Managed Health Care ("DMHC"). In addition, Customer arranges for the provision of Medi-Cal services to Medi-Cal beneficiaries under a contract with the California Department of Health Care Services ("DHCS") ("**DHCS Contract**") and Medicare Advantage ("**MA**") services to Medicare beneficiaries under a Centers for Medicare & Medicaid Services ("CMS") contract ("**CMS Contract**"). This Exhibit A sets forth the statutory, regulatory, and contractual requirements that Customer must incorporate into the Agreement as a public agency and DMHC-licensed health care service plan with MA and Medi-Cal products.

1. **Medi-Cal Requirements.**

1.1. Compliance with Medi-Cal Standards. Sitecore agrees that the Agreement shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract. Sitecore shall comply with all applicable requirements of the Medi-Cal program and comply with all required monitoring of the DHCS Contract and any other reasonable monitoring requests by DHCS.

1.2. Disclosure of Officers, Owners, Stockholders and Creditors. Pursuant to Exhibit E, Attachment 2, Section 33 (a) of the DHCS Contract and 42 C.F.R. Section 455.104, upon the Effective Date, on an annual basis, and within thirty (30) days of any changes, Sitecore shall identify the names of the following persons by listing them on Exhibit B of this Agreement and submitting the form to Customer:

1.2.1. All officers and owners who own greater than five percent (5%) of the Sitecore;

1.2.2. All stockholders owning greater than five percent (5%) of any stock issued by Sitecore; and

1.2.3. All creditors of Sitecore's business if such interest is over five percent (5%).

1.3. Compliance with Employment and Labor Laws. Each party shall, at its own expense, comply with all Applicable Laws in performing their respective obligations under the Agreement, including, but not limited to, the National Labor Relations Act, the Americans With Disabilities Act, all applicable employment discrimination laws, overtime laws, tax laws, immigration laws, workers' compensation laws, occupational safety and health laws, and unemployment insurance laws and any regulations related thereto. Sitecore acknowledges and agrees that, as applicable:

1.3.1. Sitecore 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. Sitecore and its subcontractors will take reasonable 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. Sitecore and its subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices provided by the federal government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Sitecore and its subcontractors' obligation to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees. [DHCS Contract, Exhibit D(F), Provision 1, Section A]

1.3.2. Sitecore and its subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Sitecore and its subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. [DHCS Contract, Exhibit D(F), Provision 1, Section B]

1.3.3. Sitecore and its subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State of California, advising the labor union or workers' representative of Sitecore and its subcontractors' commitments under this Section 1.3 and shall post copies of the notice in conspicuous places available to employees and applicants for employment. [DHCS Contract, Exhibit D(F), Provision 1, Section C]

1.3.4. Sitecore and its subcontractors will comply with all applicable provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212), and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", and of the rules, regulations, and relevant orders of the Secretary of Labor. [DHCS Contract, Exhibit D(F), Provision 1, Section D]

1.3.5. Sitecore and its subcontractors will furnish all information and reports required by Federal Executive Order No. 11246, as amended and as applicable to Sitecore, including by Executive Order 11375, "Amending Executive Order No. 11246, Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders. [DHCS Contract, Exhibit D(F), Provision 1, Section E]

1.3.6. If Sitecore and its subcontractors' do not comply with the requirements of this Section 1.3 or with any federal rules, regulations, or orders referenced herein as applicable to Sitecore,

this Agreement may be cancelled, terminated, or suspended in whole or in part, and Sitecore and its subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246, as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law. [DHCS Contract, Exhibit D(F), Provision 1, Section F]

1.3.7. Sitecore and its subcontractors will include the provisions of this Section 1.3 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor. Sitecore and its subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that if Sitecore and its subcontractors become involved in, or are threatened with litigation by a subcontractor as a result of such direction by DHCS, Sitecore and its subcontractors may request in writing to DHCS, which, in turn, may request the United States to enter into such litigation to protect the interests of the State of California and of the United States. [DHCS Contract, Exhibit D(F), Provision 1.G]

1.4. Debarment and Suspension Certification.

1.4.1. By signing the Agreement, the Sitecore agrees to comply with any and all applicable federal suspension and debarment regulations, including, as applicable, 7 C.F.R. 3017, 45 C.F.R. 76, 40 C.F.R. 32, or 34 C.F.R. 85. [DHCS Contract, Exhibit D(F), Provision 19, Section A]

1.4.2. By signing the Agreement, Sitecore agrees and acknowledges based on its actual knowledge and belief, that it and its principals:

1.4.2.1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any state or federal department or agency; [DHCS Contract, Exhibit D(F), Provision 19, Section B.1]

1.4.2.2. Have not within a three (3)-year period preceding this Agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction; violation of federal or state anti-trust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false

statements, or receiving stolen property; [DHCS Contract, Exhibit D(F), Provision 19, Section B.2]

1.4.2.3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the offenses enumerated in Section 1.4.2.2 of this Exhibit C; [DHCS Contract, Exhibit D(F), Provision 19, Section B.3]

1.4.2.4. Have not within a three (3)-year period preceding the Effective Date of this Agreement had one or more public transactions (federal, state or local) terminated for cause or default; [DHCS Contract, Exhibit D(F), Provision 19, Section B.4]

1.4.2.5. Have not and shall not knowingly enter into any lower-tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 C.F.R. 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State of California; and [DHCS Contract, Exhibit D(F), Provision 19, Section B.5]

1.4.2.6. Will include a clause entitled, "Debarment and Suspension Certification" that sets forth the provisions herein in all lower-tier covered transactions and in all solicitations for lower-tier covered transactions. [DHCS Contract, Exhibit D(F), Provision 19, Section B.6]

1.4.3. If the Sitecore is unable to certify to any of the statements in this certification, the Sitecore shall submit an explanation to Customer. [DHCS Contract, Exhibit D(F), Provision 19, Section C]

1.4.4. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549. [DHCS Contract, Exhibit D(F), Provision 19, Section D]

1.4.5. If the Sitecore knowingly violates this certification, in addition to other remedies available to the federal government, Customer may terminate this Agreement for cause or default. [DHCS Contract, Exhibit D(F), Provision 19, Section E]

1.5. Lobbying Restrictions and Disclosure Certification.

1.5.1. *Certification and Disclosure Requirements*.

1.5.1.1. If Agreement is subject to 31 U.S.C. § 1352 and exceeds $100,000 at any tier, Sitecore and its subcontractors, as applicable, shall file a certification (in the form set forth in Exhibit C, consisting of one page, entitled "Certification Regarding Lobbying") that Sitecore and its subcontractors, as applicable, have not made, and will not make, any payment prohibited by Section 1.5.2 below. [DHCS Contract, Exhibit D(F), Provision 31, Section A.1; 31 U.S.C. § 1352]

1.5.1.2. Sitecore and its subcontractors, as applicable, shall file a disclosure (in the form set forth in Exhibit C, entitled "Certification Regarding Lobbying") if Sitecore and its subcontractors, as applicable, have made or agreed to make any payment using

non-appropriated funds (to include profits from any covered federal action) in connection with the Agreement or a subcontract thereunder that would be prohibited under Section 1.5.2 below if paid for with appropriated funds. [DHCS Contract, Exhibit D(F), Provision 31, Section A.2]

1.5.1.3. Sitecore and its subcontractors, as applicable, shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by Sitecore and its subcontractors, as applicable, under this Section 1.5.1. An event that materially affects the accuracy of the information reported includes: [DHCS Contract, Exhibit D(F), Provision 31, Section A.3]

1.5.1.3.1. A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action; [DHCS Contract, Exhibit D(F), Provision 31, Section A.3.a]

1.5.1.3.2. A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or [DHCS Contract, Exhibit D(F), Provision 31, Section A.3.b]

1.5.1.3.3. A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action. [DHCS Contract, Exhibit D(F), Provision 31, Section A.3.c]

1.5.1.3.4. As applicable and required by this Section 1.5, Sitecore's subcontractors shall file a certification and a disclosure form, if required, to the next tier above. [DHCS Contract, Exhibit D(F), Provision 31, Section A.4]

1.5.1.3.5. All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by Sitecore. Sitecore shall forward all disclosure forms to Customer. [DHCS Contract, Exhibit D(F), Provision 31, Section A.5]

1.5.2. *Prohibition*. 31 U.S.C. § 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. [DHCS Contract, Exhibit D(F), Provision 31, Section B]

1.6. Verification of Customer Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Agreement or completion of any audit, or longer as required by applicable regulations, Sitecore will make available, upon written request of Customer, the Secretary of Health and Human Services Office of Inspector General, the Comptroller General of the United States, the U.S. Department of Justice, DHCS, the DMHC, the

Bureau of Medical Fraud, or any of their duly authorized representatives copies of this Agreement and any financial statements, books, documents, records, patient care documentation, and other records or data of Sitecore that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Agreement, or as are otherwise necessary to certify the nature and extent of costs incurred by Customer for such services. This provision shall also apply to any agreement with a Sitecore subcontractor or an organization related to a Sitecore subcontractor by control or common ownership. Sitecore 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. Sitecore further agrees and acknowledges that this provision will be included in any and all agreements with Sitecore's subcontractors. [DHCS Contract, Exhibit E, Attachment 2, Provision 20]

1.7. Confidentiality of Member Information.

1.7.1. If Sitecore and its employees, agents, or subcontractors access or receive, whether intentionally or unintentionally, personally identifying information during the Term, Sitecore and its employees, agents, and subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Agreement, or persons whose names or identifying information become available or are disclosed to Sitecore, its employees, agents, or subcontractors as a result of services performed under this Agreement, except for statistical information not identifying any such person. Sitecore and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out the express terms of and Sitecore's obligations under this Agreement. Sitecore and its employees, agents, or subcontractors shall promptly transmit to Customer all requests for disclosure of such identifying information, except requests for medical records in accordance with applicable law, not emanating from the Customer member. Sitecore shall not disclose, except as otherwise specifically permitted by this Agreement or authorized by the Customer member, any such identifying information to anyone other than DHCS or Customer without prior written authorization from Customer specifying that the information is releasable under Title 42 C.F.R. Section 431.300 *et seq.*, Section 14100.2, Welfare and Institutions Code, and regulations adopted there under. For purposes of this Section 1.7, identity shall include name, identifying number, symbol, or other identifying detail assigned to the individual, such as finger or voice print or a photograph. [DHCS Contract, Exhibit D(F), Provision 12, Exhibit E, Attachment 2, Provision 22, Section B]

1.7.2. Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 C.F.R. Section 431.300 *et seq.*, Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Agreement, all information, records, data, and data elements collected and maintained for the operation of the Agreement and pertaining to Customer members shall be protected by Sitecore from unauthorized disclosure. With respect to any identifiable information concerning a Customer member under this Agreement that is obtained by Sitecore or its subcontractors, Sitecore will, at the termination of this Agreement and upon receipt of a written request by Customer, return all such information to Customer or maintain such information according to written procedures sent to the

Sitecore by Customer for this purpose. [DHCS Contract, Exhibit E, Attachment 2, Provision 22]

1.8. Air and Water Pollution Requirements. If this Agreement or any subcontract thereunder is in excess of one hundred thousand dollars ($100,000), Sitecore agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 *et seq.*), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 *et seq.*), as amended. [DHCS Contract, Exhibit D(F), Provision 11]

2. **Medicare Requirements.**

2.1. Sitecore expressly agrees that Sitecore and Sitecore's subcontractors, if any, shall comply with all applicable Medicare laws and regulations. Sitecore further agrees and acknowledges that this provision will be included in all agreements with Sitecore's subcontractors.

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

2.3. Abide by all federal and state laws regarding confidentiality and disclosure of medical records and other health and enrollment information. Sitecore shall safeguard the privacy of any information that identifies a particular enrollee and shall have procedures that specify: (a) the purposes for which the information will be used within Sitecore's organization; and (b) to whom and for what purposes Sitecore will disclose the information.

2.4. Ensure that the medical information is used and released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas.

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

2.6. Sitecore shall comply with the applicable reporting requirements provided in 42 C.F.R. § 422.516, as well as the encounter data submission requirements in 42 C.F.R. § 422.257.

2.7. For all contracts in the amount of $100,000 or more, Sitecore and Sitecore's subcontractors, if any, and if applicable to Sitecore and its subcontractors, shall comply with 41 C.F.R. 60-300.5(a) and 41 C.F.R. 60-741.5(a) as follows:

2.7.1. Sitecore and its subcontractors shall abide by the requirements of 41 C.F.R. § 60-300.5(a). This regulation prohibits discrimination against qualified protected veterans and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified protected veterans. [41 C.F.R. § 60-300.5(d)]

2.7.2. Sitecore and its subcontractors shall abide by the requirements of 41 C.F.R. § 60-741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities. [41 C.F.R. § 60-741.5(d)]

2.8. While Customer maintains ultimate responsibility for adhering to and complying with all terms and conditions of the CMS Contract, Sitecore shall comply with all such applicable requirements in the CMS Contract, at the direction of Customer.

2.9. Sitecore shall ensure that the persons it employs or contracts with for the provision of services pursuant to the Agreement are in good standing and not on the preclusion list, defined in 42 C.F.R. § 422.2. Sitecore shall promptly disclose to Customer any exclusion or other event that makes a Sitecore employee or subcontractor ineligible to perform work related to federal health care programs. Sitecore agrees to be bound by the provisions set forth at 2 C.F.R. Part 376. [42 C.F.R. § 422.752(a)(8)]

3. **Offshore Performance**.

3.1. Due to security and identity protection concerns, direct services under this Agreement, as described in Exhibit D, shall not be performed by offshore subcontractors, unless otherwise authorized in writing by Customer prior to the provision of those services.

3.2. Sitecore shall complete, sign, and return Exhibit D, "Attestation Concerning the Use of Offshore Subcontractors" as of the Effective Date and shall submit an executed Offshore Subcontractor Attestation to Customer upon Customer's request, and not more than once annually. Sitecore represents and warrants that it has disclosed in Exhibit D any and all such offshore subcontractors and that it has obtained Customer's written approval to use such offshore subcontractors prior to the Effective Date.

3.3. Any subcontract with an offshore entity under which the offshore entity will have access to any confidential Customer information must be approved in writing by Customer prior to execution of the subcontract. Sitecore is required to submit future Offshore Contractor Attestations to Customer within thirty (30) calendar days after it has signed a contract with any subcontractor that may be using an offshore subcontractor to perform any related work.

3.4. Unless specifically stated otherwise in this Agreement, the restrictions of this Section 3 do not apply to indirect or "overhead" services, or services that are incidental to the performance of the Agreement.

3.5. The provisions of this Section 3 apply to work performed by subcontractors at all tiers.

4. **Prohibited Interest**.

4.1. Sitecore shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict-of-interest laws, including Customer's Conflict of Interest Code, the California Political Reform Act (California Government Code § 81000 *et seq.*) and California Government Code § 1090 *et seq.* (collectively, the "**Conflict of Interest Laws**").

4.2. Sitecore agrees that, to the best of its knowledge during the Term, no director, officer, or employee of Customer during his or her tenure has any interest, direct or indirect, in this Agreement or the proceeds thereof.

4.3. Sitecore understands that if this Agreement is made in violation of California Government Code § 1090 *et seq.*, the entire Agreement is voidable, Sitecore will not be entitled to any compensation

for services performed pursuant to this Agreement, and Sitecore will be required to reimburse Customer any sums paid to Sitecore. Sitecore further understands that Sitecore may be subject to criminal prosecution for a violation of California Government Code § 1090.

4.4. If Sitecore becomes aware of any facts that might reasonably be expected to either create a conflict of interest under the Conflict of Interest Laws or violate the provisions of this Section 4, Sitecore shall immediately make full written disclosure of such acts to Customer. Full written disclosure shall include identification of all persons, entities, and businesses implicated and a complete description of all relevant circumstances.

5. **State Auditor Audit Disclosure**. Pursuant to California Government Code § 8546.7, if this Agreement is more than ten thousand dollars ($10,000), it is subject to examination and audit of the California State Auditor, at the request of Customer or as part of any audit of Customer for a period of three (3) years after final payment under this Agreement. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Agreement, Sitecore agrees that during the Term and for a period of three (3) years after its termination, Customer shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of Sitecore relating to services provided under this Agreement. Where another right of access or inspection in this Agreement provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period. [Gov't Code § 8546.7]

6. **Subcontractors.** The parties agree that the use of the term "subcontractor" within this Exhibit A does not include or contemplate "Subprocessor" as defined in in the Data Processing Addendum.

7. **No Disclosure of Protected Health Information**. Customer does not contemplate disclosing Protected Health Information ("**PHI**") to Sitecore under this Agreement. Accordingly, Customer will not knowingly disclose or make any PHI available to Sitecore. Prior to disclosing any PHI under this Agreement, the parties will execute an addendum describing each party's respective rights and obligations with respect to PHI.

EXHIBIT B
Medi-Cal Disclosure Form

Sitecore Officer, Owner, Shareholder, and Creditor Information

Sitecore's Business Name: _Sitecore USA, Inc._____

Business Entity Type: ___Delaware Corporation _____
(*Sole Proprietorship, Partnership, LLC, California Corporation, etc.*)

Business Address: __101 California St, Ste 1600_____

City:___San Francisco_____ State:____CA_____ Zip:____94111_____
Business Phone:_____855-748-3267_____ Email: : joseph.roldan@sitecore.com
President: __Mike Fenn_____ Contact Person:__Joseph Roldan_____

Person(s) Signing Contract & Title: :___Mike Fenn, President North America_____

*Please provide names of owners, officers, stockholders, and creditors of Sitecore's business if such interest is over 5%.

Name	Officer Title or Ownership/Creditorship %
Sitecore USA Holding, LLC	___100%_____
_____	_____
	_____
	_____

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.

DocuSigned by:
Mike Fenn
8C3A1C87F2194F9...
Authorized Signature

21 December 2022
Date

Mike Fenn, President North America
Name and Title

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EXHIBIT C

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.

Sitecore USA, Inc	**Mike Fenn**
Name of Contractor	Printed Name of Person Signing for Contractor
	DocuSigned by: Mike Fenn 8C3A1C87F2194F9...
Contract/Grant Number	Signature of Person Signing for Contractor
21 December 2022	**President North America**
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
☐a. contract ☐b. grant ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	☐a. bid/offer/application ☐b. initial award ☐c. post-award	☐a. initial filing ☐b. material change **For Material Change Only:** Year _____ quarter_____ date of last report _____

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
☐ Prime ☐ Subawardee Tier ____, *if known*: Congressional District, *if known*:	Congressional District, *if known*:
6. Federal Department/Agency:	7. Federal Program Name/Description: CDFA Number, *if applicable*:
8. Federal Action Number, *if known*:	9. Award Amount, *if known*: $_____
10. a. Name and Address of Lobbying Entity (*If individual, last name, first name, MI*):	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):

(attach Continuation Sheet(s) SF-LLLA, if necessary)

11. Amount of Payment (check all that apply): $_____ ☐actual ☐planned	13. Type of Payment ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other, specify: _____
12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature _____ Value_____	

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, if necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: ☐Yes ☐No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only | Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.
2. Identify the status of the covered federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.
4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.
5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.
6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.
7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."
9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.
10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.
12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.
13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.
14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.
16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

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EXHIBIT D

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Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima prior to entering into or amending any agreement with an Offshore Subcontractor, and Contractor must complete the Offshore Subcontracting Attestation.

Which CalOptima program(s) does this form pertain to? Select all that apply.	☐ OneCare Connect ☐ PACE ☐ OneCare ☐ Medi-Cal

Please check one of the following:

☒ Our Organization does not offshore any protected health information.
Please skip to Part V below

☐ Our Organization does offshore protected health information.
Please complete Offshore Subcontractor Attestation (Part I through Part V) below

Part I — Offshore Subcontractor Information	
Attestation	**Response**
Our Organization uses an offshore subcontractor or offshore staff to perform functions that support our contract with CalOptima	☐ Yes ☐ No
Offshore Subcontractor name:	
Offshore Subcontractor country:	
Offshore Subcontractor address:	
Describe offshore subcontractor functions:	
Proposed or actual effective date for offshore subcontractor (MM/DD/Year):	

Part II — Precautions for Protected Health Information (PHI)	
Question	**Response**
1. Describe the PHI that will be provided to the offshore subcontractor	
2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's objectives:	
3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

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Part III — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract	
Attestation	**Response**
A. Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary protected health information (PHI) and other personal information remains secure.	☐ Yes ☐ No*
B. Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with CalOptima's contract with the offshore subcontractor.	☐ Yes ☐ No*
C. Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐ Yes ☐ No*
D. Offshore subcontracting arrangement includes all required Medicare Part C and D language (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.)	☐ Yes ☐ No*

Part IV — Attestation of Audit Requirements to Ensure Protection of PHI	
Attestation	**Response**
A. Our Organization will conduct an annual audit of the offshore subcontractor/employee.	☐ Yes ☐ No*
B. Audit results will be used by our Organization to evaluate the continuation of its relationship with the offshore subcontractor/employee.	☐ Yes ☐ No*
C. Our Organization agrees to share offshore subcontractor's/employee's audit results with CalOptima or CMS upon request.	☐ Yes ☐ No*

***Explanation required for all "no" responses to Part III and Part IV above:**

Part V — Organization Information	
By signing below, I hereby attest that the information contained herein is true, correct and complete.	
Printed name of authorized person: Mike Fenn	Title: President, North America, Sitecore USA, Inc.
Email:	Phone #:
Signature: DocuSigned by: Mike Fenn 8C3A1C87F2194F9...	Date: 21 December 2022

Note: CalOptima's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima's Code of Conduct, CalOptima's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.aspx

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Exhibit E

Policy:	GA.5004
Title:	**Travel Policy**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 03/04/2022*
Effective Date:	08/01/2012
Revised Date:	03/03/2022
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes a uniform standard and process for reasonable and equitable reimbursement of approved travel, transportation, meals, lodging, and other actual and necessary business-related expenses incurred by CalOptima employees, Governing Body, Standing Committee members, and authorized contractors and consultants while conducting authorized CalOptima Business.

II. POLICY

A. CalOptima shall comply with all applicable laws and regulations to provide and reimburse Authorized Individuals for business-related expenses, which includes travel, Travel Meals, Transportation, Registration Fees, and other Reimbursable Expenses. The Finance Department shall implement an approval and reimbursement process to ensure timely and accurate identification, approval, processing, recording, payment, and monitoring of all necessary travel, transportation, meals, lodging, and miscellaneous expenses incurred by Authorized Individuals, in accordance with generally accepted accounting principles (GAAP), and in compliance with State and Federal laws and regulations.

B. CalOptima shall reimburse Authorized Individuals for reasonable, actual, and necessary expenses incurred while conducting CalOptima Business. Reimbursements for CalOptima business-related expenses shall be made in accordance with the Internal Revenue Services (IRS) requirements, particularly the rules for an accountable plan, which requires: (1) expenses to have a business connection; (2) expenses be adequately accounted for within a reasonable period of time; and (3) any excess reimbursement or allowance be returned within a reasonable period of time. Reimbursement may be authorized when there is a clear connection or nexus between the attendance of the individual at such activity or function and the performance of official duties for which such individual is regularly employed.

C. Business-related expenses for travel while conducting CalOptima Business 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, avoiding peak travel times, and leveraging efficiency by combining multiple meetings and events wherever possible. Employees are expected to use good judgment when traveling, seeking to minimize travel costs whenever possible. Reimbursable travel expenses include actual and necessary expenses, such as:

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1. Transportation: Including commercial carriers, rental vehicles, mileage for use of personal vehicle, taxi, recognized ride-share companies, shuttle, and public transit fares.

    a. In selecting the mode of Transportation, the Authorized Individual shall consider 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.

    b. The Authorized 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.

        i. Authorized Individuals may, for personal convenience, travel to their final destination on an indirect route, or on an interrupted direct route, if approved in advance within the Travel and Training Authorization form. An Authorized 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.

        ii. Additional expenses shall not be the responsibility of the Authorized Individual if, through no fault or control of the Authorized 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.

        iii. Whenever available, all Authorized 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, unless First or Business Class is shown to be cheaper than coach.

        iv. 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.

        v. Any deviation from the lowest available rate for commercial carriers shall be at the individual's expense.

    c. The Authorized Individual shall be responsible for necessary cancellation of travel reservations, in accordance with the respective carrier rules and time limits. CalOptima shall not reimburse Authorized 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 Authorized Individual. The Authorized Individual must also inform CalOptima's Vendor Management Department of any such cancellations.

    d. Use of Privately-Owned Vehicles

        i. 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.

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ii. CalOptima shall reimburse the use of privately-owned vehicles solely based on actual mileage at the Internal Revenue Service (IRS) Standard Mileage Rate to be reviewed annually. Total mileage reimbursed should exclude the individual's daily commute (Offset Mileage).

iii. For Authorized Individuals who receive an automobile allowance pursuant to CalOptima Policy GA. 8042: Supplemental Compensation, CalOptima will only reimburse actual mileage at the IRS Standard Mileage Rate for travel that exceeds a round-trip of 100 miles based on the distance of the final destination from the individual's primary workplace. Use of privately-owned vehicles within a round-trip of 100 miles or less per meeting or event based on the distance of the final destination from the individual's primary workplace is covered as part of the automobile allowance.

iv. CalOptima shall not reimburse costs for fuel, automobile repairs, other automobile expense items, or traffic/parking citations.

v. 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.

vi. Travel shall be by the most practical direct route. Any person traveling by an indirect route shall assume any additional expense incurred.

vii. CalOptima shall compensate property damages to an Authorized Individual's automobile incurred without fault or cause on the part of the Authorized Individual up to two hundred fifty dollars ($250), or the amount of the deductible on the person's insurance policy, whichever is the lesser amount, for each accident.

e. Rental Automobiles

i. An Authorized Individual may rent an automobile when such rental is considered to be more advantageous to CalOptima than other means of Transportation.

ii. Advance reservations shall be made whenever possible. Reservations for the Authorized Individual and the vehicle rental agreement shall be made in the person's name, acting for CalOptima. i.e., John Doe, for CalOptima.

iii. Rental automobile approved classes are as follows:

a) Economy Class or equivalent: An Authorized Individual shall select an economy class vehicle whenever four (4) or fewer Authorized Individuals, including the driver, will be passengers in the rental automobile at any one time.

b) Mid-size Class or equivalent: An Authorized Individual may select a mid-size class vehicle in the event more than four (4) Authorized 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 or if the cost is lower than that of an economy class (Documented support required).

c) Luxury Class or equivalent: Under no circumstances shall an individual select a luxury class vehicle.

f. Other Modes of Transportation

i. Taxi Fares or Shuttles: CalOptima shall reimburse taxi fares or shuttles when public Transportation is not practical or available. Examples include travel between hotel and place of business, and from one business to another.

ii. Ride Sharing Company: CalOptima does not encourage the use of Ride Sharing Companies, such as Uber or Lyft; however, if no other modes of transportation is available or economical, CalOptima will reimburse Ride Sharing Company fares. Authorized Individuals shall use Ride Sharing Companies at their own risk and discretion, with no liability to CalOptima, understanding the dangers of using such services. Customary and reasonable transportation tips/gratuity may be reimbursed.

g. Costs associated with any personal travel made in conjunction with a business travel itinerary will be at the Authorized Individual's expense. Authorized Individuals are expected to be honest in reporting any personal travel plans made in conjunction with a business travel, and the Authorized Individual shall document the incremental travel costs assessed to CalOptima in accordance with this Policy.

2. Lodging

a. CalOptima shall reimburse the cost of a single room at an Approved Lodging Facility for Non-local Travel.

b. Reasonable lodging expenses will be allowed. Price is a factor when selecting lodging, and prudence and good stewardship should be used when selecting a lodging facility. Comparison shopping is encouraged, and booking through online travel websites, as opposed to directly with the lodging facility, may provide opportunities for reduced cost lodging. Itemized receipts for lodging must be provided to obtain reimbursement.

c. 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: https://www.gsa.gov/travel/plan-book/per-diem-rates.

d. CalOptima maintains preferred rates with select hotels in the local area. Vendors and consultants conducting CalOptima Business who are required to stay overnight and are authorized to receive reimbursement for lodging expenses pursuant to a contract with CalOptima, should utilize these preferred hotels. Authorized Individuals should contact a member of the CalOptima Vendor Management Department for information and a link to the reservations department of these preferred hotels.

e. CalOptima may reimburse additional lodging expenses for Non-local Travel if:

i. It results in offsetting lower airfare; and

ii. 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.

f. Local Travel may qualify for an overnight stay, depending on time constraints. CalOptima may approve Local Travel lodging expenses if:

i. It is not practical or feasible for the Authorized Individual to return home due to extremely poor weather conditions; or

ii. 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.

g. Once approved, the Authorized 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 Vendor Management Department.

h. The Authorized 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 Authorized 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 Authorized Individual. The Authorized Individual must also inform CalOptima's Vendor Management Department of any cancellations.

3. Travel Meals

a. Travel Meals are those food items consumed when traveling on CalOptima Business away from the primary workplace.

b. CalOptima may reimburse Authorized Individuals the actual cost of Travel Meals, including taxes and gratuity (up to 20% of the Authorized Individual's meal) and excluding alcoholic beverages in an amount not to exceed eighty dollars ($80.00) per day.

c. Under certain conditions, CalOptima may reimburse employees and Board members for Travel Meals that exceed the eighty dollars ($80.00) per day limit. The employee or Board member shall submit a valid receipt for such Travel Meals along with a brief explanation of the expenditure which must meet the following conditions:

i. 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.

ii. Expense Reports containing extraordinary meal expenditures shall require approval of the CEO, or his or her Designee.

d. CalOptima may negotiate individual meal per diem amounts for individual contractors authorized to receive reimbursement for expenses. Individual contractor per diem rates may be less than, but shall not exceed, the established employee, Board and Committee member Travel Meal reimbursement rate.

4. Registration Fees: For attending conferences, seminars, conventions, or meetings of professional societies or community organizations;

a. Attendance at any given conference and/or seminar shall be:

i. Limited to the minimum number of individuals necessary to carry out the business purpose as deemed appropriate by the designated Approver as specified below for that particular conference or seminar;

ii. For only those whose job tasks or responsibilities are directly related to the purpose of the travel; and

iii. Approved by the Department Head and Human Resources.

b. Payment of Fees

i. 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 will submit necessary registration information to the Vendor Management Department.

ii. 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.

5. Miscellaneous expenses, including:

a. Insurance for rental vehicles;

b. Parking fees and toll fees (i.e., charges for toll roads and necessary parking);

c. Authorized local and long-distance telephone calls;

d. Baggage fees;

e. Internet or Wi-Fi charges for business-related communication;

f. Facsimiles;

g. Expenses in connection with the preparation of authorized company reports or correspondence; and

h. Other unforeseen or unusual business-related expenses that are properly justified and substantiated.

6. The type of expenses or occurrences that do not qualify for travel reimbursement of expenses include, but are not limited to:

a. Attendance at social, civic, or charitable meetings or functions, which the person would attend regardless of his or her position.

b. Any expenditure or contributions related to political campaigning or charitable fundraisers or events.

c. Expenses for anyone other than the Authorized Individual attending or participating in the activity or function.

d. The personal portion of any travel.

e. Entertainment expenses, including movies, sporting events, or concerts.

f. Personal losses incurred while on CalOptima business.

D. CalOptima may reimburse the reasonable cost of Business Meals for required meetings, trainings, or other functions where CalOptima business is conducted. Expenditure of or reimbursement with CalOptima funds is only permitted for Business Meals if such expenditure is pre-authorized in writing by the Chief Executive Officer (CEO) and the Chief Financial Officer (CFO) prior to the meeting, training or other business-related function. Under no circumstances or conditions will Business Meals, payments or reimbursements be permitted for:

1. Social functions or events, including, but not limited to, the following:

   a. Holiday parties (with the exception of an organization-wide event);

   b. Birthdays;

   c. Baby showers;

   d. Marriage celebrations;

   e. Retirements;

   f. Department-only employee appreciation or celebration;

   g. Other personal employee celebrations;

   h. Expenditures for alcoholic beverages, including related tax and tip; and/or

   i. Voluntary events or functions, including, but not limited to, employee lunch time and/or after work group outings, team building events, and/or other off-site social functions (with the exception of training and self-development programs established and/or approved by the Human Resources Department).

E. Cash advances

1. Under normal circumstances, CalOptima shall not issue cash advances for travel expenses.

2. CalOptima may authorize cash advances on a limited basis if the traveling Authorized Individual does not possess sufficient means of credit or other financial resources to cover the cost of one (1) or more authorized travel expenses.

3. A member of the Executive Staff will need to approve requests for cash advances for anticipated authorized travel.
4. When authorized, cash advances shall be based on an estimate of reasonable travel expenses, including transportation, meals, lodging and miscellaneous expenses, and shall have a limit of $1,000 unless approved in advance by the CFO.

5. Cash advances shall not be provided earlier than thirty (30) days prior to the scheduled travel date(s). Authorized Individuals receiving cash advances shall complete an Expense Report within sixty (60) days of when the Authorized Individual's expenses were paid or incurred,

whichever occurs first. The Authorized Individual shall account for all expenses incurred while traveling on authorized CalOptima Business, and shall indicate and remit any cash amounts due back to CalOptima within one hundred and twenty (120) days of when the expenses were paid or incurred in the event the cash advance was greater than actual authorized expenses. In the event the actual authorized expenses exceed the amount of the cash advance, cash amounts due the individual will be processed in the following pay period. Failure to return unexpended cash advances or to account for all expenses incurred while traveling may result in corrective action, up to and including termination.

III. PROCEDURE

A. Travel and Training Authorization Form

1. All travel requests and requests for anticipated reimbursement of related expenses must be submitted on-line by Authorized 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. Such requests shall be routed for approval based on the Authorized Individual's level, cost center, and whether the Authorized Individual is a CalOptima employee according to the following:

   a. Individual Departments are responsible for including anticipated travel expenses in the Department budget.

   b. Budgeted Expenses: All budgeted travel and miscellaneous expenses for Authorized Individuals must be approved by the appropriate level of CalOptima Senior 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 Staff
Executive Director	Departmental Chief or Designee
Departmental Chief Officers	CEO or Designee
Chief Executive Officer	CFO or Designee
Board Member/Standing Committee Member	CEO or Designee

   c. Non-Budgeted Expenses: Non-budgeted travel and miscellaneous expenses for Authorized Individuals may be approved if the expenditures are appropriated and authorized in accordance with CalOptima Policy GA.5003: Budget and Operations Forecasting prior to travel expenses being incurred.

3. All requests will also be routed to the Human Resources Department in order to track the Authorized Individual's training.

4. The Finance Department will review all requests to verify 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 Vendor Management Department shall review, authorize for appropriate approvals, and notify the requestors that they may begin making travel arrangements if not already completed by the Vendor Management Department.

B. Travel and Training Arrangements

1. Authorizations that include event Registration Fees shall be pre-paid and processed by CalOptima's Vendor Management Department, where possible. CalOptima's Vendor Management Department shall verify with the requestor that the registration has not been processed before proceeding with registration of the Authorized 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 Vendor Management Department and will be reimbursed using an Expense Report.

3. All other arrangements shall be made with the Authorized 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 Vendor Management Department approval.

C. Expense Reimbursement using an Expense Report

1. Authorized 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, receipts and documentation, 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 Staff
Executive Director	Departmental Chief or Designee
Departmental Chief Officers	CEO or Designee
Chief Executive Officer	CFO or Designee
Board Member/Standing Committee Member	CEO or Designee

*Designee authorization is not valid when self-approval would result.

2. Receipts

a. For each expense, 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. The receipt shall include line item details of all eligible charges being submitted for reimbursement. CalOptima contractors authorized to receive reimbursement for expenses shall submit receipts for all expenses, regardless of the dollar amount of the expenditure, identifying the line item(s) for qualifying charges, as appropriate.

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, but in no event beyond sixty (60) days after the expense is paid or incurred.

4. No reimbursement shall be made for Expense Reports submitted beyond sixty (60) days after completion of travel.

D. The Accounting Department shall:

1. Review submitted Expense Reports and supporting documentation for completeness;

a. During the review, Accounting will contact Authorized Individual to request for missing supporting documentation'

b. Accounting will provide advance communication of any denied reimbursement claims; and

c. Authorized Individual may dispute denied reimbursement claims by providing a narrative and/or additional supporting documentation to be reviewed by the Controller.

2. Review expense codes for appropriate department and general ledger account numbers; and

3. Process payment for reimbursement.

E. The Vendor Management Department shall:

1. Provide travel reports to the CEO, Executive Staff and Department Directors, upon request. Such reports may include a summary of travel by department, purpose, cost, and number of individuals per event.

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 Vendor Management to arrange attendance at conferences, trainings, 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. ATTACHMENT(S)

A. CalOptima Expense Report

V. REFERENCE(S)

A. Bylaws of Orange County Health Authority dba Orange Prevention and Treatment Integrated Medical Assistance, Adopted December 6, 1994
B. CalOptima Policy GA.8042: Supplemental Compensation
C. Internal Revenue Service Publication 463
D. California Government Code Section 53232.2
E. California Labor Code Section 2802
F. Title 26, Code of Federal Regulations §§ 1.62-2

VI. REGULATORY AGENCY APPROVAL(S)

Not Applicable

VII. BOARD ACTION(S)

Date	Meeting
09/06/2012	Regular Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2012	GA.5004	Travel Policy	Administrative
Revised	09/06/2012	GA.5004	Travel Policy	Administrative
Revised	03/01/2013	GA.5004	Travel Policy	Administrative
Revised	03/03/2022	GA.5004	Travel Policy	Administrative

IX. GLOSSARY

Term	Definition
Authorized Individual	Persons authorized to submit an Expense Report for reimbursement of travel, meal, lodging, or other allowable expenses, 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.
Approved Lodging Facility	Any overnight sleeping facilities which offers a discounted government rate to authorized individuals traveling on behalf of CalOptima.
Business Meals	Breakfast, lunch, dinner, snacks, refreshments, and related tips and taxes where business is discussed with peers or business associates over the course of a meal.
CalOptima Business	Activities or functions which a department head determines are directly related to or in support of the ordinary, necessary and/or required mission and business functions of CalOptima.
CalOptima Employees	Includes, but are not limited to, all full-time and part-time regular CalOptima employees, all temporary employees, interns, CalOptima Board members, and applicable contractors and consultants.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Executive Staff	Staff holding Executive level positions as designated by the Board of Directors.
Expense Report	Detailed and itemized report that tracks expenses a person incurred during the course of performing necessary job functions.
Governing Body	The Board of Directors of CalOptima.
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Board of Directors who provide advice and recommendations regarding the organization's investments.
Local Travel	Travel to a destination that is 50 miles or less away from the primary workplace or home and does not generally include an overnight stay.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Non-local Travel	Travel which is more than 50 miles away from the primary workplace or home and may require an overnight stay.
Non-Reimbursable Expenses	Expenses that are not a necessary part of or approved as part of the required travel. Commuting between a traveler's home and regularly assigned work location is not considered official business.
Parking, Fees and Tolls	Charges for ferries, bridges, tunnels, toll roads, and necessary parking.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima to advise its Board of Directors on issues impacting the CalOptima Provider community.

Term	Definition
Registration Fees	Actual fees paid for registration to attend authorized conferences, seminars, conventions, trainings or meetings of professional societies or community organizations.
Reimbursable Expenses	Travel expenses which are reasonable, actual, and necessary to accomplish CalOptima's business purposes and are eligible for reimbursement. Reimbursable expenses include but are not limited to the cost of transportation, meals, lodging, registration fees, insurance for rental vehicles and other incidental expenses incurred while traveling on CalOptima business.
Standing Committee Members	Non-Board and non-employee members of the CalOptima Investment Advisory Committee (IAC), Provider Advisory Committee (PAC), Member Advisory Committee (MAC), OneCare Connect MAC, and Whole Child Model Family Advisory Committee.
Transportation	Bus, rail or airfare, car rental, taxi, ride sharing, shuttle, parking fees, tolls, and mileage for use of personal vehicle.
Travel Meals	Travel Meals are those food items consumed when traveling on CalOptima business that is considered Non-local Travel.

Sitecore Customer Order

Customer:	CalOptima
Company/Tax ID No:	
Customer Address:	505 City Parkway West Orange, California 92868 United States
Sitecore:	Sitecore USA, Inc.
Address:	44 Montgomery, Suite 3340 San Francisco, CA, USA 94104
Order Voidability Date	February 16, 2024
Order Effective Date	This Order will be effective on the date signed by both parties below.
Existing Master Terms Date (where applicable)	December 21, 2022

This Order is entered into between Sitecore and Customer under the master agreement executed between the parties as of the Existing Master Terms Date, including any cloud addendum entered into by the parties, if applicable (collectively, the **'Master Terms'**). This Order will be governed by the Master Terms and will form part of the Agreement between the parties. This Order will be effective as of the Order Effective Date. Unless otherwise defined in this Order, capitalized terms shall have the meanings set forth in the Master Terms. This Order is voidable at Sitecore's option if not signed by Customer on or before the Order Voidability Date.

1. Sitecore Products

SAAS PRODUCT:

Sitecore will provide the following SaaS Product and entitlements:

Quantity	Description
1	Sitecore Experience Manager Cloud (Standard)
1	Vercel Enterprise 1.5TB

Entitlement	Entitlement Value
Visits Year 1	2,000,000
Visits Year 2	2,000,000
Visits Year 3	2,000,000
Projects	1
Production Environments	1
Non Production Environments	2
Concurrent Users	10
Experience Edge Bandwidth	1 TB/ month per Project

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Experience Edge Storage	5 GB per Project

Termination of the Former Order
As of the Order Effective Date, the Hosted Services portion (Managed Cloud Standard XM) of the Former Order is terminated. As of 6 (six) months from the Order Effective Date, the Software portion (Sitecore Experience Manager) of the Former Order is terminated and Sitecore and Customer hereby agree to fully replace and supersede the Former Order with this Order Form. "Former Order" means the Sitecore Customer Order dated December 29, 2022, including any and all subsequent amendments or addenda thereto.

Licensing is enabled by electronic delivery of a License Key. Promptly after mutual execution of this Order, a new License Key will be shipped to Rick Cabral at rcabral@caloptima.org, and as of 6 (six) months from the Order Effective Date any license keys associated with the Former Order will be terminated. Notwithstanding Section 4(c) of the Master Terms, the License Key will not be time-limited.

Permitted Usage: Customer may use the SaaS Product for creation and management of Customer's own current and future public-facing web properties.

SAAS PRODUCT:
Sitecore will provide the following SaaS Product and entitlements:

Quantity	SaaS Product
1	Sitecore Experience Edge (DAM-Standard)

Experience Edge Entitlement	Entitlement Value
API Calls/Second	80
File Storage	5 GB per Edge subscription
Bandwidth	1 TB/month per Edge subscription

Permitted Usage. Permitted Usage has the same meaning as that governing Customer's use of the Sitecore Software or SAAS Product.

SAAS PRODUCT:
Sitecore will provide the following SaaS Product and entitlements:

Quantity	Description
1	Sitecore Digital Asset Management (DAM-Standard)
1	Sitecore Product Content Management (DAM-Standard)
1	Sitecore Content Hub - Digital Apps Connector - Additional Seats Pack (100)

Entitlement	Entitlement Value
Monthly Business Users Year 1	50
Monthly Business Users Year 2	50
Monthly Business Users Year 3	50
Integration Users	1
Non-Production Environments	1
Video Indexing Hours	250
Entities per 1TB of Asset Storage	250,000
Asset Storage (TB's)	1
Asset Bandwidth	1

Permitted Usage: Customer may use the SaaS Products for management and distribution of Customer's marketing content.

SAAS PRODUCT:

Sitecore will provide the following SaaS Product and entitlements:

Quantity	SaaS Product
1	Sitecore CDP (Standard)

Entitlement	Entitlement Value
Monthly Tracked Users Year 1	500,000
Monthly Tracked Users Year 2	500,000
Monthly Tracked Users Year 3	500,000
Total Events per Month Year 1	50,000,000
Total Events per Month Year 2	50,000,000
Total Events per Month Year 3	50,000,000
Production Environments	1
Non-Production Environments	1

Permitted Usage. Customer may use the SaaS Products for its own business purposes.

SAAS PRODUCT:

Sitecore will provide the following SaaS Product and entitlements:

Quantity	SaaS Product
1	Sitecore Personalize (Standard)

Entitlement	Entitlement Value

Visits per year Year 1	2,000,000
Visits per year Year 2	2,000,000
Visits per year Year 3	2,000,000
Events per year Year 1	200,000,000
Events per year Year 2	200,000,000
Events per year Year 3	200,000,000
Production Environments	1
Non-Production Environments	1

Permitted Usage. Customer may use the SaaS Products for its own business purposes.

SAAS PRODUCT:

Sitecore will provide the following SaaS Product and entitlements:

Quantity	Description
1	Sitecore Search (Standard)

	Entitlement		
Year	Visits	API Calls Per Year	Max Requests Per Minute
Year 1	2,000,000	9,600,000	202
Year 2	2,000,000	9,600,000	202
Year 3	2,000,000	9,600,000	202

Entitlement	Entitlement Value
Documents	50,000
Production Environments	1
Non Production Environments	1
Concurrent Crawlers	1
Crawler Frequency	Every 24 hours

Permitted Usage. Customer may use the SaaS Products for its own internal business purposes with respect to the Permitted Sites.

SaaS Product Entitlements:
If Customer exceeds any Entitlement for any of the above SaaS Products (with the exception of Experience Manager Cloud) at any time during any of the consecutive 12-month periods that make up a Subscription Term, then upon 15 days' prior notification Customer will automatically be upgraded to the next applicable pricing tier for the remainder of the Subscription term, unless Customer responds to such notification, in which case Customer will have the option to right-size based on a written mutual agreement between Sitecore and Customer. Automatic Upgrades will be in line with Sitecore's then-current retail prices, the annual fee will be increased accordingly, and Sitecore will immediately invoice Customer for the pro-rata amount applicable to the remaining time in the current invoicing cycle. Any exceptions to this policy will be noted in the Additional Special Terms section within this order form.

For Experience Manager Cloud: no later than the 15th calendar day following each 3-month period beginning from the effective date of the Order, Customer will submit to Sitecore a usage report identifying the number of Visits (as defined in the Order) in that 3-month period based on Customer's use of Experience Manager Cloud. Where the report indicates that Customer has exceeded its purchased number of Visits, then upon 15 days' prior notification Customer will automatically be upgraded to the next applicable pricing tier for the remainder of the Subscription Term, unless Customer responds to such notification, in which case Customer will have the option to right-size based on a written mutual agreement between Sitecore and Customer. Automatic Upgrades will be in in line with Sitecore's then-current retail prices, the annual fee will be increased accordingly, and Sitecore will immediately invoice Customer for the pro-rata amount applicable to the remaining time in the current invoicing cycle.

2. Sitecore Services

Consulting & Training

This section is not applicable to this order.

3. Support, SLA and Usage Policy

Sitecore offers support and maintenance services as set forth at https://kb.sitecore.net/articles/583182, at the level indicated in this Order.

Sitecore offers a Service Level Agreement for each of its SaaS Products and Hosted Services, which can be found at https://www.sitecore.com/legal/sla.

Access to SaaS Products and Hosted Services is provided subject to Customer's compliance with the Usage Policy set forth at https://www.sitecore.com/legal/usage-policy.

4. Sitecore360

Quantity	Description
1	Sitecore360 Standard Bundle

Entitlement	Entitlement Value	Entitlement Type
Sitecore360 Expert Services	13	Hours Per Month
Sitecore360 Professional Plus Training	16	End Users
Sitecore Premium Support	Included	N/A

A description of the Sitecore360 entitlements can be found at https://www.sitecore.com/legal/sitecore360

5. Sitecore Product Definitions

The Sitecore Product and Hosted Services definitions are as set forth on https://www.sitecore.com/legal/order-definitions .

6. Subscription Term; Renewal

This Order is effective on the Order Effective Date and continues for the minimum commitment of 36 months. At the end of this minimum commitment, the Order will automatically renew for additional terms, as set forth below, unless either party provides the other party with at least 90 days' written notice of its intent not to renew prior to the next renewal date. The 'Subscription Term' is equal to the minimum commitment plus any renewals, which will be either:

☑ additional 12-month renewal terms with an annual increase in pricing of 9%; or

☐ additional 36-month renewal terms with an annual increase in pricing of 5%.

7. Invoicing and Payment Terms

Below is a summary of the invoicing under this Order:

Year	Description	Price
1	Recurring Fee	588,644.79 USD*
1	**TOTAL**	**588,644.79 USD**
2	Recurring Fee	615,069.57 USD
3	Recurring Fee	642,818.08 USD

Upon the Order Effective Date, the initial invoice will be sent to Accounts Payable at accountspayable@caloptima.org as set forth below. The invoice will be sent to Customer's Accounts Payable Contact, as set forth at the top of this Order. *Sitecore will credit Customer's first invoice for any unused subscription fees paid to Sitecore under the Former Order, calculated on a daily basis from the Order Effective Date to the expiration of the current subscription period.

If applicable, any Recurring fees under this Order will be invoiced annually and due on the anniversary of the Order Effective Date, for the remainder of the Subscription Term.

Customer Billing Address:	505 City Pkwy W Orange, California, United States 92868-2924
Customer Shipping Address:	505 City Pkwy W Orange, California, United States 92868-2924
Customer Technical Contact Name:	Rick Cabral

Customer Technical Contact Email:	rcabral@caloptima.org

All prices as set out in this Order are USD and exclusive of any applicable taxes unless otherwise indicated.

Payment Terms
Net 30 days.

Payment terms for all amounts under this Order are **Net 30 days** from the date of a valid, undisputed invoice issued by Sitecore. An invoice shall be valid where the amounts invoiced are accurate and without regard to other referenced information including but not limited to purchase order number. In the event of non-payment by Customer of a valid undisputed invoice, if Customer still fails to pay such invoice after being sent a 15 days' reminder notice to pay such invoice, Sitecore may, at its sole discretion, suspend the access or provision of the Sitecore Products and/or Services, or terminate the affected Order. Customer agrees to pay interest calculated at the rate of six percent (6%) per annum or the maximum amount permitted by law, whichever is less, of the total outstanding amount, for the time period the payment remains past due.

Additional Terms and Conditions
On-Demand Overage rates for Vercel are as follows: $86 per 100GB per month for Additional Bandwidth; $86 per 100 GB-Hours per month for Additional Serverless Execution.

By executing this Order, Customer commits to the payments set forth above. Each person signing this Order represents and warrants that he or she has been duly authorized and has full authority to execute this Order on behalf of the party below. This Order may be executed in counterpart, and may be executed by way of facsimile or electronic signature, and if so, will be considered an original.

Sitecore		**CalOptima**	
By:	_____	By:	_____
Print Name:	_____	Print Name:	_____
Title:	_____	Title:	_____
Date:	_____	Date:	_____

CalOptima Health Board Action Agenda Referral

Action To Be Taken February 1, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
13. Receive and File Closed and Open Board Ad Hoc Committees

Contact
Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Actions
Receive and File Fiscal Year (FY) 2022-2023 Closed Board Ad Hoc Committee List and FY 2023-2024 Open Board Ad Hoc Committee List.

Background
The Ralph M. Brown Act (Brown Act) requires open and public meetings by legislative bodies of local agencies when conducting the public's business. Under the Brown Act, advisory committees composed solely of the members of the legislative body that are less than a quorum of the legislative body are not legislative bodies, where those committees are charged with specific tasks for a limited period of time.

When necessary, the Chair of the CalOptima Health Board of Directors (Board) assigns members to serve as an ad hoc committee to study an item or accomplish a specific task. Accordingly, the Board's ad hoc committees serve for a limited term and are not standing committees. Ad hoc committees serve the Board and the public by allowing members of the Board to efficiently investigate and collaborate on an item of concern consistent with the Brown Act.

Discussion
On June 2, 2022, the CalOptima Health Board adopted a resolution outlining the process for dissolving closed Board Ad Hoc Committees and reporting out of new or current Board Ad Hoc Committees. See Attachment 1.

The resolution adopted on June 2, 2022, established the policy for creating and dissolving ad hoc committees. Under the policy, the Board Chair may create ad hoc committees to serve as advisory committees on specific items for a limited period of time. The Chair identifies the committees' memberships, scopes of work, and dates of dissolution. The Clerk of the Board is charged with maintaining the list and bringing the list of ad hoc committees to the Board for review on an annual basis. Note that this agenda item was delayed until a Chair of the CalOptima Health Board was officially elected, which occurred at the December 7, 2023, meeting.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
This item officially reports out the closed Board Ad Hoc Committees and new or current Board Ad Hoc Committees in a manner consistent with established policy.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Previous Board Action dated June 2, 2022, Receive and File Open and Closed Board Ad Hoc Committees
2. FY 2022-2023 - Closed Board Ad Hoc List
3. FY 2023-2024 – Open Board Ad Hoc List

/s/ Michael Hunn *01/25/2024*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

6. Adopt Resolution Dissolving Existing Board Ad Hoc Committees and Creating New Board Ad Hoc Committees, and Establish a Policy for Administration of Ad Hoc Committees

Contact

Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Actions

Adopt resolution to:

1. Dissolve existing Board Ad Hoc Committees;
2. Create new Ad Hoc Board Committees; and
3. Establish a policy for the administration of future ad hoc committees.

Background

The Ralph M. Brown Act (Brown Act) requires open and public meetings by "legislative bodies" of local agencies when conducting the public's business. Under the Brown Act, advisory committees composed solely of the members of the legislative body that are less than a quorum of the legislative body are not "legislative bodies," where those committees are charged with specific tasks for a limited period of time.

When necessary, the Chair of the CalOptima Board of Directors (Board) assigns members to serve as an ad hoc committee to study an item or accomplish a specific task. Accordingly, the Board's ad hoc committees serve for a limited term and are not standing committees. Ad hoc committees serve the Board and the public by allowing members of the Board to efficiently investigate and collaborate on an item of concern consistent with the Brown Act.

Discussion

For administrative clarity, Staff recommends that the Board dissolve all existing ad hoc committees and create the new ad hoc committees listed in the attachment to this proposed resolution, which includes the following information:

- Name of the ad hoc committee;
- Committee's membership;
- Limited scope of the ad hoc committee's task; and
- Date that the ad hoc committee will dissolve.

The proposed resolution establishes the policy for creating and dissolving ad hoc committees. Under the proposed policy, the Board Chair may create an ad hoc committee to serve as an advisory committee on a specific item for a limited period of time. The Chair will identify the committee's membership, scope of work, and date of dissolution. The Clerk of the Board will be charged with maintaining the list and bringing the list and ad hoc committee policy to the Board for review on an annual basis.

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Fiscal Impact
There is no financial impact.

Rationale for Recommendation
This item will provide clarity on CalOptima's use of ad hoc committees in a manner consistent with the Brown Act.

Concurrence
Troy R. Sabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed Resolution
2. Proposed Ad Hoc List

Board Action(s)
None

/s/ Michael Hunn *05/27/2022*
Authorized Signature **Date**

RESOLUTION NO. 22-0602-03

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

RESOLUTION FOR CALOPTIMA BOARD AD HOC COMMITTEES

WHEREAS, the Ralph M. Brown Act is California's "Open Meetings" or "Sunshine" law that requires open and public meetings by legislative bodies of local agencies when conducting the public's business;

WHEREAS, the Brown Act provides that, unless certain conditions are satisfied, a legislative body is prohibited from discussing or acting on any item not appearing on the posted agenda of a public meeting;

WHEREAS, under the Brown Act, advisory committees composed solely of members of the legislative body that are less than a quorum of the legislative body are not "legislative bodies," where those committees do not have a continuing subject matter jurisdiction and do not have a meeting schedule fixed by formal action of the legislative body;

WHEREAS, ad hoc committees serve for a limited period of time on discrete items or tasks as directed by the Chair of the Board;

WHEREAS, advisory committees shall be comprised of no more than four members of the CalOptima Board of Directors and assist the Board and the public it serves in efficiently investigating and collaborating on items of concern; and

WHEREAS, to ensure Brown Act compliance and for administrative clarity, the Board should identify which ad hoc committees are currently active and adopt a policy for the administration of ad hoc committees.

NOW, THEREFORE, BE IT RESOLVED:

1. That the CalOptima Board of Directors hereby:
    a. Dissolves all existing ad hoc committees; and
    b. Creates the ad hoc committees listed in Attachment 2, subject to the membership, scope of work, and dissolution dates listed in Attachment 2.

2. That the Board of Directors hereby adopts the following policy for the administration of ad hoc committees:
    a. At any meeting of the CalOptima Board of Directors, the Chair may create ad hoc committees composed of no more than four Board members to serve as an advisory committee on a specific item for a limited period of time. Where the Chair creates an ad hoc committee, he or she will identify the committee's membership, scope of work, work product, and date of dissolution.

b. The Clerk of the Board shall maintain a list of active ad hoc committees.
c. On an annual basis, the Clerk of the Board shall place on the Board's meeting agenda a review of the ad hoc committee list and policy.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of June 2022.

AYES: _____

NOES: _____

ABSENT: _____

ABSTAIN: _____

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Andrew Do, Chair, CalOptima Board of Directors

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

CalOptima Board Ad Hoc Committees –
FY 2022 - 2023

Ad Hoc Committee	Ad Hoc Members	Date Established	Scope of Work	Work Product	Dissolution Date
Homeless Health Initiatives Ad Hoc	Andrew Do Doug Chaffee Clayton Corwin Nancy Shivers	6/2/2022	Review the homeless health initiatives consistent with street medicine and the Homeless Health Incentive Program.	Oral Report to the Board.	To be closed at the end of FY 2022-2023.
Audit Ad Hoc	Isabel Becerra Clayton Corwin Clayton Chau Scott Schoeffel	6/2/2022	To review prepared responses, findings, results and corrective action plans issues by CMS and DHCS.	Oral Report to the Board.	To be closed upon receipt of final report from CMS and DHCS or no later than the end of FY 2022-2023.
Legislative Ad Hoc/Ad Hoc will be responsible for the initial review of legislative bills that are in alignment with the Board-approved legislative platform.	Andrew Do Clayton Corwin Scott Schoeffel Clayton Chau	6/2/2022	To review legislative proposals within the jurisdiction of the legislative platform.	Report provided in the CEO Direct Reports.	To be closed upon no later than the end of FY 2022-2023.
Strategic Planning Ad Hoc/ Ad Hoc will review CalOptima's strategic planning and growth.	Andrew Do Blair Contratto Clayton Corwin Scott Schoeffel	6/2/2022	Provide regular input and feedback on the strategic planning effort.	Oral Report to the Board.	To be closed at the end of FY 2022-2023.

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CalOptima Health Board Ad Hoc Committees

FY 2022 – 2023

CLOSED

Ad Hoc Committee	Ad Hoc Members	Date Established	Scope of Work	Work Product	Dissolution Date
Homeless Health Initiatives Ad Hoc	Andrew Do Doug Chaffee Clayton Corwin Nancy Shivers	6/2/2022	Review the homeless health initiatives consistent with street medicine and the Homeless Health Incentive Program.	Oral Report to the Board.	12/8/2023
Audit Ad Hoc	Isabel Becerra Clayton Corwin Clayton Chau Scott Schoeffel	6/2/2022	To review prepared responses, findings, results and corrective action plans issues by CMS and DHCS.	Oral Report to the Board.	12/8/2023
Legislative Ad Hoc/Ad Hoc will be responsible for the initial review of legislative bills that are in alignment with the Board-approved legislative platform.	Andrew Do Clayton Corwin Scott Schoeffel Clayton Chau	6/2/2022	To review legislative proposals within the jurisdiction of the legislative platform.	Report provided in the CEO Direct Reports.	12/8/2023
Strategic Planning Ad Hoc/ Ad Hoc will review CalOptima's strategic planning and growth.	Andrew Do Blair Contratto Clayton Corwin Scott Schoeffel	6/2/2022	Provide regular input and feedback on the strategic planning effort.	Oral Report to the Board.	12/8/2023

CalOptima Health Board Ad Hoc Committees
FY 2023 - 2024

Ad Hoc Committee	Ad Hoc Members	Date Established	Scope of Work	Work Product	Dissolution Date
1090 Investigation Ad Hoc	Clayton Corwin Blair Contratto	05/04/2023	Looking into the 1090 investigation brought up in the California State Audit Report to see if there was any wrongdoing by the CalOptima Health Board	Oral report back to the Board	TBD
Governance Ad Hoc	Blair Contratto, Ad Hoc Chair Isabel Becerra Vicente Sarmiento	09/08/2023	Responsible for drafting initial Board Rules of Procedures and outline a more formal process for election of officers and other Board processes	Oral and written Board processes Board approved policy for Election of Officers 11/2/23 Board approved using Rosenberg's Rules of Procedure for conducting CalOptima Health Board of Directors meetings on 12/7/2023	TBD
Strategic Planning Ad Hoc	Clayton Corwin Isabel Becerra Jose Mayorga, M.D. Doug Chaffee	01/25/2024	Responsible for providing regular feedback and guidance on CalOptima Health's Strategic Planning efforts.	Oral report back to the Board	TBD

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Financial Summary

November 30, 2023

Board of Directors Meeting
February 1, 2024

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: November 2023

November 2023					July - November 2023			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
963,968	927,107	36,861	4.0%	Member Months	4,882,706	4,798,308	84,398	1.8%
364,157,238	339,772,756	24,384,482	7.2%	Revenues	1,980,333,339	1,754,594,027	225,739,312	12.9%
341,424,329	316,661,347	(24,762,982)	(7.8%)	Medical Expenses	1,809,573,580	1,635,801,248	(173,772,332)	(10.6%)
19,079,720	21,098,550	2,018,830	9.6%	Administrative Expenses	90,858,405	103,458,347	12,599,942	12.2%
3,653,189	2,012,859	1,640,330	81.5%	Operating Margin	79,901,354	15,334,432	64,566,922	421.1%
21,127,545	2,083,330	19,044,215	914.1%	Net Investment Income/Expense	72,456,122	10,416,650	62,039,472	595.6%
(23,210)	(89,380)	66,170	74.0%	Net Rental Income/Expense	5,870	(276,899)	282,769	102.1%
-	(1,003,219)	1,003,219	(100.0%)	Grant Expense	(28,965,738)	(25,016,097)	(3,949,641)	(15.8%)
-	-	-	0.0%	Other Income/Expense	(830,003)	-	(830,003)	(100.0%)
21,104,336	990,731	20,113,605	2,030.2%	Total Non-Operating Income (Loss)	42,666,250	(14,876,346)	57,542,596	386.8%
24,757,524	**3,003,590**	**21,753,935**	**724.3%**	**Change in Net Assets**	**122,567,605**	**458,086**	**122,109,519**	**26,656.4%**
93.8%	*93.2%*	*0.6%*		*Medical Loss Ratio*	*91.4%*	*93.2%*	*(1.9%)*	
5.2%	*6.2%*	*1.0%*		*Administrative Loss Ratio*	*4.6%*	*5.9%*	*1.3%*	
93.8%	*93.2%*	*0.6%*		*MLR (excluding Directed Payments)*	*90.7%*	*93.2%*	*(2.5%)*	
5.2%	*6.2%*	*1.0%*		*ALR (excluding Directed Payments)*	*4.9%*	*5.9%*	*1.0%*	

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CalOptima Health

FY 2023-24: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) November 2023: $24.8 million, favorable to budget $21.8 million or 724.3% driven primarily by slower disenrollment in Medi-Cal, favorable performance and net investment income
  - Year To Date (YTD) July - November 2023: $122.6 million, favorable to budget $122.1 million or 26,656.4% due to favorable performance and net investment income
- Enrollment
  - MTD: 963,968 members, favorable to budget 36,861 or 4.0%
  - YTD: 4,882,706 member months, favorable to budget 84,398 or 1.8%

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CalOptima Health

FY 2023-24: Management Summary (cont.)

- Revenue
  - MTD: $364.2 million, favorable to budget $24.4 million or 7.2% driven by the Medi-Cal (MC) Line of Business (LOB)
    - Due primarily to retroactive member months and favorable enrollment mix
  - YTD: $1,980.3 million, favorable to budget $225.7 million or 12.9%
    - Driven primarily by Calendar Year (CY) 2022 Hospital Directed Payments (DP) and favorable enrollment

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CalOptima Health

FY 2023-24: Management Summary (cont.)

- Medical Expenses
  - MTD: $341.4 million, unfavorable to budget $24.8 million or 7.8%
    - Managed Long-Term Services and Supports (MLTSS) expense unfavorable variance of $12.4 million due to a true-up to the Department of Health Care Services (DHCS) newly released CY 2023 Long-Term Care (LTC) rates
    - Community Support (CS) services and Ground Emergency Medical Transportation (GEMT) related expenses unfavorable variance of $15.0 million due to higher than anticipated volume and rate
  - YTD: $1,809.6 million, unfavorable to budget $173.8 million or 10.6%
    - Driven primarily by CY 2022 Hospital DP

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CalOptima Health

FY 2023-24: Management Summary (cont.)

- Administrative Expenses
  - MTD: $19.1 million, favorable to budget $2.0 million or 9.6%
  - YTD: $90.9 million, favorable to budget $12.6 million or 12.2%

- Non-Operating Income (Loss)
  - MTD: $21.1 million, favorable to budget $20.1 million or 2,030.2% due primarily to net investment income
  - YTD: $42.7 million, favorable to budget $57.5 million or 386.8% due primarily to net investment income

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CalOptima Health

FY 2023-24: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 93.8% (93.8% excluding DP), Budget 93.2%
  - YTD: Actual 91.4% (90.7% excluding DP), Budget 93.2%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 5.2% (5.2% excluding DP), Budget 6.2%
  - YTD: Actual 4.6% (4.9% excluding DP), Budget 5.9%
- Balance Sheet Ratios
  - Current ratio*: 1.6
  - Board Designated Reserve level: 1.84
  - Net-position: $1.8 billion, including required Tangible Net Equity (TNE) of $112.9 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: November 2023

November 2023					July - November 2023			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
144,153	138,420	5,733	4.1%	SPD	717,539	702,546	14,993	2.1%
296,211	308,781	(12,570)	(4.1%)	TANF Child	1,500,475	1,570,016	(69,541)	(4.4%)
138,904	125,558	13,346	10.6%	TANF Adult	710,030	650,627	59,403	9.1%
2,844	3,118	(274)	(8.8%)	LTC	14,623	15,590	(967)	(6.2%)
352,330	321,546	30,784	9.6%	MCE	1,792,195	1,711,786	80,409	4.7%
11,432	11,415	17	0.1%	WCM	56,907	56,935	(28)	(0.0%)
945,874	**908,838**	**37,036**	**4.1%**	**Medi-Cal Total**	**4,791,769**	**4,707,500**	**84,269**	**1.8%**
17,648	**17,799**	**(151)**	**(0.8%)**	**OneCare**	**88,751**	**88,500**	**251**	**0.3%**
446	**470**	**(24)**	**(5.1%)**	**PACE**	**2,186**	**2,308**	**(122)**	**(5.3%)**
491	**568**	**(77)**	**(13.6%)**	**MSSP**	**2,491**	**2,840**	**(349)**	**(12.3%)**
963,968	**927,107**	**36,861**	**4.0%**	**CalOptima Health Total**	**4,882,706**	**4,798,308**	**84,398**	**1.8%**

*CalOptima Health Total does not include MSSP

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CalOptima Health

Consolidated Revenue & Expenses: November 2023 MTD

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	593,544	352,330	945,874	17,648		446	491	963,968
REVENUES								
Capitation Revenue	$ 190,718,078	$ 136,155,746	$ 326,873,824	$ 33,252,396	$ 10,810	$ 3,807,064	$ 213,144	$ 364,157,238
Total Operating Revenue	**190,718,078**	**136,155,746**	**326,873,824**	**33,252,396**	**10,810**	**3,807,064**	**213,144**	**364,157,238**
MEDICAL EXPENSES								
Provider Capitation	56,559,037	46,127,477	102,686,514	12,964,789				115,651,303
Claims	78,820,552	47,672,633	126,493,186	6,520,584	24,538	1,474,161		134,512,469
MLTSS	54,878,353	7,464,807	62,343,160		(1,800)	(37,932)	24,544	62,327,973
Prescription Drugs	-			9,306,197		467,722		9,773,920
Case Mgmt & Other Medical	9,506,261	6,371,659	15,877,920	1,983,427	(4,579)	1,160,113	141,784	19,158,665
Total Medical Expenses	**199,764,203**	**107,636,576**	**307,400,779**	**30,774,997**	**18,159**	**3,064,065**	**166,329**	**341,424,329**
Medical Loss Ratio	*104.7%*	*79.1%*	*94.0%*	*92.5%*	*168.0%*	*80.5%*	*78.0%*	*93.8%*
GROSS MARGIN	**(9,046,125)**	**28,519,170**	**19,473,045**	**2,477,399**	**(7,349)**	**743,000**	**46,815**	**22,732,909**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			11,173,556	1,006,636		170,167	89,539	12,439,898
Non-Salary Operating Expenses			2,769,761	290,797		(8,587)	1,335	3,053,306
Depreciation & Amortization			859,144			1,118		860,263
Other Operating Expenses			2,338,950	37,771		6,458	6,387	2,389,566
Indirect Cost Allocation, Occupancy			(556,777)	873,504		14,059	5,900	336,687
Total Administrative Expenses			**16,584,635**	**2,208,708**	**-**	**183,216**	**103,162**	**19,079,720**
Administrative Loss Ratio			*5.1%*	*6.6%*	*0.0%*	*4.8%*	*48.4%*	*5.2%*
Operating Income/(Loss)			**2,888,410**	**268,691**	**(7,349)**	**559,784**	**(56,347)**	**3,653,189**
Investments and Other Non-Operating			-					21,104,336
CHANGE IN NET ASSETS			**$ 2,888,410**	**$ 268,691**	**$ (7,349)**	**$ 559,784**	**$ (56,347)**	**$ 24,757,524**
BUDGETED CHANGE IN NET ASSETS			4,315,520	(2,278,271)	-	48,792	(73,182)	3,003,590
Variance to Budget - Fav/(Unfav)			$ (1,427,110)	$ 2,546,962	$ (7,349)	$ 510,992	$ 16,835	$ 21,753,935

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CalOptima Health

Consolidated Revenue & Expenses: November 2023 YTD

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	2,999,574	1,792,195	4,791,769	88,751		2,186	2,491	4,882,706
REVENUES								
Capitation Revenue	$ 1,040,925,543	$ 759,650,604	$1,800,576,147	$ 161,389,845	$ (1,356,316)	$ 18,658,621	$ 1,065,043	$ 1,980,333,339
Total Operating Revenue	**1,040,925,543**	**759,650,604**	**1,800,576,147**	**161,389,845**	**(1,356,316)**	**18,658,621**	**1,065,043**	**1,980,333,339**
MEDICAL EXPENSES								
Provider Capitation	304,770,298	243,632,854	548,403,152	64,733,614				613,136,767
Claims	373,594,344	238,905,181	612,499,525	33,026,422	(1,828)	7,597,201		653,121,320
MLTSS	219,330,438	29,313,104	248,643,542	-	(19,416)	73,480	115,645	248,813,252
Prescription Drugs	(11,660)		(11,660)	43,941,621	(1,822,950)	2,359,658		44,466,669
Case Mgmt & Other Medical	139,655,535	96,801,404	236,456,939	7,096,204	86,200	5,638,319	757,911	250,035,573
Total Medical Expenses	**1,037,338,955**	**608,652,543**	**1,645,991,498**	**148,797,861**	**(1,757,995)**	**15,668,659**	**873,556**	**1,809,573,580**
Medical Loss Ratio	*99.7%*	*80.1%*	*91.4%*	*92.2%*	*129.6%*	*84.0%*	*82.0%*	*91.4%*
GROSS MARGIN	**3,586,588**	**150,998,061**	**154,584,649**	**12,591,983**	**401,678**	**2,989,962**	**191,487**	**170,759,759**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			53,934,818	4,955,044	(0)	797,430	469,963	60,157,255
Non-Salary Operating Expenses			10,656,889	1,488,581	(4,364)	43,751	6,692	12,191,549
Depreciation & Amortization			4,387,723			5,612		4,393,335
Other Operating Expenses			11,854,702	299,888		47,911	25,336	12,227,837
Indirect Cost Allocation, Occupancy			(2,578,831)	4,367,521		70,238	29,501	1,888,429
Total Administrative Expenses			**78,255,301**	**11,111,035**	**(4,364)**	**964,941**	**531,492**	**90,858,405**
Administrative Loss Ratio			*4.3%*	*6.9%*	*0.3%*	*5.2%*	*49.9%*	*4.6%*
Operating Income/(Loss)			**76,329,348**	**1,480,948**	**406,043**	**2,025,021**	**(340,005)**	**79,901,354**
Investments and Other Non-Operating			(830,003)					42,666,250
CHANGE IN NET ASSETS			**$ 75,499,344**	**$ 1,480,948**	**$ 406,043**	**$ 2,025,021**	**$ (340,005)**	**$ 122,567,605**
BUDGETED CHANGE IN NET ASSETS			26,955,875	(11,530,811)	-	269,490	(360,122)	458,086
Variance to Budget - Fav/(Unfav)			$ 48,543,469	$ 13,011,759	$ 406,043	$ 1,755,531	$ 20,117	$ 122,109,519

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CalOptima Health

Balance Sheet: As of November 2023

ASSETS	
Current Assets	
Operating Cash	$787,560,580
Short-term Investments	1,682,516,212
Receivables & Other Current Assets	510,699,603
Total Current Assets	**2,980,776,395**
Capital Assets	
Capital Assets	163,972,883
Less Accumulated Depreciation	(72,484,659)
Capital Assets, Net of Depreciation	91,488,225
Other Assets	
Restricted Deposits	300,000
Board Designated Reserve	621,522,686
Total Other Assets	**621,822,686**
TOTAL ASSETS	**3,694,087,306**
Deferred Outflows	**75,969,067**
TOTAL ASSETS & DEFERRED OUTFLOWS	**3,770,056,373**

LIABILITIES & NET POSITION	
Current Liabilities	
Accounts Payable	$13,836,194
Medical Claims Liability and Capitation Payable	1,681,968,155
Capitation and Withholds	138,647,911
Other Current Liabilities	56,521,043
Total Current Liabilities	**1,890,973,303**
Other Liabilities	
GASB 96 Subscription Liabilities	15,655,923
Postemployment Health Care Plan	19,212,627
Net Pension Liabilities	40,465,145
Total Other Liabilities	**75,333,695**
TOTAL LIABILITIES	**1,966,306,999**
Deferred Inflows	**11,175,516**
Net Position	
TNE	112,882,602
Funds in Excess of TNE	1,679,691,256
TOTAL NET POSITION	**1,792,573,858**
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**3,770,056,373**

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CalOptima Health

Board Designated Reserve and TNE Analysis: As of November 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	253,962,350				
	Tier 1 - MetLife	251,984,945				
Board Designated Reserve		505,947,294	360,495,474	563,371,792	145,451,821	(57,424,498)
	Tier 2 - Payden & Rygel	57,931,193				
	Tier 2 - MetLife	57,644,199				
TNE Requirement		115,575,391	112,882,602	112,882,602	2,692,789	2,692,789
	Consolidated:	**621,522,686**	**473,378,076**	**676,254,394**	**148,144,610**	**(54,731,709)**
	Current reserve level	*1.84*	*1.40*	*2.00*		

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CalOptima Health

Net Assets Analysis: As of November 2023

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 11/30/2023	**$1,792.6**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**621.5**			**34.7%**
	Capital Assets, net of Depreciation[2]	**91.5**			**5.1%**
Resources Allocated[3]	Homeless Health Initiative[4]	$18.7	$59.9	$41.2	1.0%
	Housing and Homelessness Initiative Program[4]	69.3	97.2	27.9	3.9%
	Intergovernmental Transfers (IGT)	58.5	111.7	53.2	3.3%
	Digital Transformation and Workplace Modernization	63.7	100.0	36.3	3.6%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	Outreach Strategy for CalFresh, Redetermination support, and other program	6.1	8.0	1.9	0.3%
	Coalition of Orange County Community Health Centers Grant	30.0	50.0	20.0	1.7%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	0.7	1.0	0.3	0.0%
	General Awareness Campaign	0.7	2.7	2.0	0.0%
	Member Health Needs Assessment	0.8	1.0	0.2	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	146.4	153.5	7.1	8.2%
	Medi-Cal Annual Wellness Initiative	2.0	3.8	1.8	0.1%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.6%
	In-Home Care Pilot Program with the UCI Family Health Center	1.6	2.0	0.4	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	4.5	5.0	0.5	0.3%
	Community Living and PACE center (previously approved for project located i	17.6	18.0	0.4	1.0%
	Stipend Program for Master of Social Work Students	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program	2.1	2.7	0.6	0.1%
	CalOptima Health Provider Workforce Development Fund	50.0	50.0	0.0	2.8%
	Distribution Event- Naloxone	2.5	15.0	12.5	0.1%
	Garden Grove Bldg Improvement	10.4	10.5	0.1	0.6%
	Post-Pandemic Supplemental	80.4	107.5	27.1	4.5%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	2.1%
	Subtotal:	**$614.1**	**$868.5**	**$254.4**	**34.3%**
Resources Available for New Initiativ	Unallocated/Unassigned[1]	**$465.4**			**26.0%**

[1] Total of Board Designated Reserve and unallocated reserve amount can support approximately 94 days of CalOptima Health's current operations

[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements

[3] Initiatives that have been paid in full in the previous year are omitted from the list of Resources Allocated

[4] See HHI and HHIP summaries and Allocated Funds for list of Board approved initiatives

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CalOptima Health

Homeless Health Initiative and Allocated Funds: As of November 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 & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	662,709	300,552
FQHC (Community Health Center) Expansion	21,902	21,902	-
HCAP and CalOptima Health Days	9,888,914	3,170,400	6,718,514
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine	8,276,652	3,711,671	4,564,981
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[1]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$ 100,000,000**	**$ 41,203,732**	**$ 58,796,268**
Transfer of funds to HHIP[1]	(40,100,000)	-	(40,100,000)
Program Total	**$ 59,900,000**	**$ 41,203,732**	**$ 18,696,268**

Notes:

[1]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP.

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Housing and Homelessness Incentive Program As of November 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	382,200	417,800
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	1,461,149	2,560,162
Infrastructure Projects	5,832,314	2,785,365	3,046,949
Capital Projects	73,247,369	21,000,000	52,247,369
System Change Projects	10,180,000	-	10,180,000
Non-Profit Healthcare Academy	354,530	56,013	298,517
Total of Approved Initiatives	**$ 97,235,524** [1]	**$ 27,884,727**	**$ 69,350,798**

Notes:

[1]Total funding $97.2M: $40.1M Board-approved reallocation from HHI, $22.3M from CalOptima Health existing reserves and $34.8M from DHCS HHIP incentive payments

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UNAUDITED FINANCIAL STATEMENTS

November 30, 2023

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CalOptima Health - Consolidated
Financial Highlights
For the Five Months Ending November 30, 2023

November 2023					July - November 2023			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
963,968	927,107	36,861	4.0%	Member Months	4,882,706	4,798,308	84,398	1.8%
364,157,238	339,772,756	24,384,482	7.2%	Revenues	1,980,333,339	1,754,594,027	225,739,312	12.9%
341,424,329	316,661,347	(24,762,982)	(7.8%)	Medical Expenses	1,809,573,580	1,635,801,248	(173,772,332)	(10.6%)
19,079,720	21,098,550	2,018,830	9.6%	Administrative Expenses	90,858,405	103,458,347	12,599,942	12.2%
3,653,189	**2,012,859**	**1,640,330**	**81.5%**	**Operating Margin**	**79,901,354**	**15,334,432**	**64,566,922**	**421.1%**
				Non-Operating Income (Loss)				
21,127,545	2,083,330	19,044,215	914.1%	Net Investment Income/Expense	72,456,122	10,416,650	62,039,472	595.6%
(23,210)	(89,380)	66,170	74.0%	Net Rental Income/Expense	5,870	(276,899)	282,769	102.1%
-	(1,003,219)	1,003,219	(100.0%)	Grant Expense	(28,965,738)	(25,016,097)	(3,949,641)	(15.8%)
-	-	-	0.0%	Other Income/Expense	(830,003)	-	(830,003)	(100.0%)
21,104,336	**990,731**	**20,113,605**	**2030.2%**	**Total Non-Operating Income (Loss)**	**42,666,250**	**(14,876,346)**	**57,542,596**	**386.8%**
24,757,524	**3,003,590**	**21,753,935**	**724.3%**	**Change in Net Assets**	**122,567,605**	**458,086**	**122,109,519**	**26656.4%**
93.8%	93.2%	0.6%		Medical Loss Ratio	91.4%	93.2%	(1.9%)	
5.2%	6.2%	1.0%		Administrative Loss Ratio	4.6%	5.9%	1.3%	
1.0%	0.6%	0.4%		Operating Margin Ratio	4.0%	0.9%	3.2%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
93.8%	93.2%	0.6%		*MLR (excluding Directed Payments)	90.7%	93.2%	(2.5%)	
5.2%	6.2%	1.0%		*ALR (excluding Directed Payments)	4.9%	5.9%	1.0%	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

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CalOptima Health - Consolidated
Full Time Employee Data
For the Five Months Ending November 30, 2023

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1255	1352	97
OneCare	183	197	14
PACE	105	101	(4)
MSSP	19	24	5
Total	1561	1673	112

Total FTE's YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	6270	6762	492
OneCare	913	985	72
PACE	518	503	(15)
MSSP	101	118	17
Total	7802	8367	565

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	754	672	(82)
OneCare	97	90	(7)
PACE	4	5	1
MSSP	26	24	(2)
Consolidated	617	554	(63)

MM per FTE YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	764	696	(68)
OneCare	97	90	(7)
PACE	4	5	1
MSSP	25	24	(1)
Consolidated	626	573	(53)

Open Positions			
	Total	Medical	Admin
Medi-Cal	92.50	35.75	56.75
OneCare	6.00	3.00	3.00
PACE	4.00	4.00	0.00
MSSP	3.00	3.00	0.00
Total	105.50	45.75	59.75

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses
For the One Month Ending November 30, 2023

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	963,968		927,107		36,861	
REVENUE						
Medi-Cal	$ 326,873,824	$ 345.58	$ 304,063,525	$ 334.56	$ 22,810,299	$ 11.02
OneCare	33,252,396	1,884.20	31,454,195	1,767.19	1,798,201	117.01
OneCare Connect	10,810		-		10,810	-
PACE	3,807,064	8,536.02	4,001,518	8,513.87	(194,454)	22.15
MSSP	213,144	434.10	253,518	446.33	(40,374)	(12.23)
Total Operating Revenue	364,157,238	377.77	339,772,756	366.49	24,384,482	11.28
MEDICAL EXPENSES						
Medi-Cal	307,400,779	324.99	281,627,534	309.88	(25,773,245)	(15.11)
OneCare	30,774,997	1,743.82	31,064,396	1,745.29	289,399	1.47
OneCare Connect	18,159				(18,159)	-
PACE	3,064,065	6,870.10	3,751,748	7,982.44	687,684	1,112.34
MSSP	166,329	338.75	217,669	383.22	51,340	44.47
Total Medical Expenses	341,424,329	354.19	316,661,347	341.56	(24,762,982)	(12.63)
GROSS MARGIN	22,732,909	23.58	23,111,409	24.93	(378,500)	(1.35)
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	12,439,898	12.90	12,620,990	13.61	181,092	0.71
Professional Fees	983,583	1.02	1,173,295	1.27	189,712	0.25
Purchased Services	1,673,822	1.74	2,278,498	2.46	604,676	0.72
Printing & Postage	395,901	0.41	542,126	0.58	146,225	0.17
Depreciation & Amortization	860,263	0.89	400,900	0.43	(459,363)	(0.46)
Other Expenses	2,389,566	2.48	3,637,862	3.92	1,248,296	1.44
Indirect Cost Allocation, Occupancy	336,687	0.35	444,879	0.48	108,192	0.13
Total Administrative Expenses	19,079,720	19.79	21,098,550	22.76	2,018,830	2.97
INCOME (LOSS) FROM OPERATIONS	3,653,189	3.79	2,012,859	2.17	1,640,330	1.62
INVESTMENT INCOME						
Interest Income	13,229,517	13.72	2,083,330	2.25	11,146,187	11.47
Realized Gain/(Loss) on Investments	35,218	0.04	-	-	35,218	0.04
Unrealized Gain/(Loss) on Investments	7,862,811	8.16	-	-	7,862,811	8.16
Total Investment Income	21,127,545	21.92	2,083,330	2.25	19,044,215	19.67
NET RENTAL INCOME	(23,210)	(0.02)	(89,380)	(0.10)	66,170	0.08
TOTAL GRANT EXPENSE	-	-	(1,003,219)	(1.08)	1,003,219	1.08
CHANGE IN NET ASSETS	**24,757,524**	**25.68**	**3,003,590**	**3.24**	**21,753,935**	**22.44**
MEDICAL LOSS RATIO	**93.8%**		**93.2%**		**0.6%**	
ADMINISTRATIVE LOSS RATIO	**5.2%**		**6.2%**		**1.0%**	

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CalOptima Health- Consolidated - Year to Date
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2023

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	4,882,706		4,798,308		84,398	
REVENUE						
Medi-Cal	$ 1,800,576,147	$ 375.76	$ 1,576,355,537	$ 334.86	$ 224,220,610	$ 40.90
OneCare	161,389,845	1,818.46	157,270,030	1,777.06	4,119,815	41.40
OneCare Connect	(1,356,316)		-		(1,356,316)	0.00
PACE	18,658,621	8,535.51	19,700,870	8,535.91	(1,042,249)	(0.40)
MSSP	1,065,043	427.56	1,267,590	446.33	(202,547)	(18.77)
Total Operating Revenue	1,980,333,339	405.58	1,754,594,027	365.67	225,739,312	39.91
MEDICAL EXPENSES						
Medi-Cal	1,645,991,498	343.50	1,460,748,506	310.30	(185,242,992)	(33.20)
OneCare	148,797,861	1,676.58	155,527,815	1,757.38	6,729,954	80.80
OneCare Connect	(1,757,995)				1,757,995	0.00
PACE	15,668,659	7,167.73	18,436,582	7,988.12	2,767,923	820.39
MSSP	873,556	350.68	1,088,345	383.22	214,789	32.54
Total Medical Expenses	1,809,573,580	370.61	1,635,801,248	340.91	(173,772,332)	(29.70)
GROSS MARGIN	170,759,759	34.97	118,792,779	24.76	51,966,980	10.21
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	60,157,255	12.32	62,256,826	12.97	2,099,571	0.65
Professional Fees	3,222,379	0.66	5,358,620	1.12	2,136,241	0.46
Purchased Services	6,554,089	1.34	10,861,120	2.26	4,307,031	0.92
Printing & Postage	2,415,080	0.49	2,852,630	0.59	437,550	0.10
Depreciation & Amortization	4,393,335	0.90	2,004,500	0.42	(2,388,835)	(0.48)
Other Expenses	12,227,837	2.50	17,900,256	3.73	5,672,419	1.23
Indirect Cost Allocation, Occupancy	1,888,429	0.39	2,224,395	0.46	335,966	0.07
Total Administrative Expenses	90,858,405	18.61	103,458,347	21.56	12,599,942	2.95
INCOME (LOSS) FROM OPERATIONS	79,901,354	16.36	15,334,432	3.20	64,566,922	13.16
INVESTMENT INCOME						
Interest Income	63,887,144	13.08	10,416,650	2.17	53,470,494	10.91
Realized Gain/(Loss) on Investments	(2,245,113)	(0.46)	-	0.00	(2,245,113)	(0.46)
Unrealized Gain/(Loss) on Investments	10,814,090	2.21	-	0.00	10,814,090	2.21
Total Investment Income	72,456,122	14.84	10,416,650	2.17	62,039,472	12.67
NET RENTAL INCOME	5,870	0.00	(276,899)	(0.06)	282,769	0.06
TOTAL GRANT EXPENSE	(28,965,738)	(5.93)	(25,016,097)	(5.21)	(3,949,641)	(0.72)
OTHER INCOME/EXPENSE	(830,003)	(0.17)	-	0.00	(830,003)	(0.17)
CHANGE IN NET ASSETS	**122,567,605**	**25.10**	**458,086**	**0.10**	**122,109,519**	**25.00**
MEDICAL LOSS RATIO	**91.4%**		**93.2%**		**(1.9%)**	
ADMINISTRATIVE LOSS RATIO	**4.6%**		**5.9%**		**1.3%**	

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CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending November 30, 2023

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	593,544	352,330	945,874	17,648		446	491	963,968
REVENUES								
Capitation Revenue	$ 190,718,078	$ 136,155,746	$ 326,873,824	$ 33,252,396	$ 10,810	$ 3,807,064	$ 213,144	$ 364,157,238
Total Operating Revenue	**190,718,078**	**136,155,746**	**326,873,824**	**33,252,396**	**10,810**	**3,807,064**	**213,144**	**364,157,238**
MEDICAL EXPENSES								
Provider Capitation	56,559,037	46,127,477	102,686,514	12,964,789				115,651,303
Claims	78,820,552	47,672,633	126,493,186	6,520,584	24,538	1,474,161		134,512,469
MLTSS	54,878,353	7,464,807	62,343,160		(1,800)	(37,932)	24,544	62,327,973
Prescription Drugs	-			9,306,197		467,722		9,773,920
Case Mgmt & Other Medical	9,506,261	6,371,659	15,877,920	1,983,427	(4,579)	1,160,113	141,784	19,158,665
Total Medical Expenses	**199,764,203**	**107,636,576**	**307,400,779**	**30,774,997**	**18,159**	**3,064,065**	**166,329**	**341,424,329**
Medical Loss Ratio	*104.7%*	*79.1%*	*94.0%*	*92.5%*	*168.0%*	*80.5%*	*78.0%*	*93.8%*
GROSS MARGIN	**(9,046,125)**	**28,519,170**	**19,473,045**	**2,477,399**	**(7,349)**	**743,000**	**46,815**	**22,732,909**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			11,173,556	1,006,636		170,167	89,539	12,439,898
Non-Salary Operating Expenses			2,769,761	290,797		(8,587)	1,335	3,053,306
Depreciation & Amortization			859,144			1,118		860,263
Other Operating Expenses			2,338,950	37,771		6,458	6,387	2,389,566
Indirect Cost Allocation, Occupancy			(556,777)	873,504		14,059	5,900	336,687
Total Administrative Expenses			**16,584,635**	**2,208,708**	**-**	**183,216**	**103,162**	**19,079,720**
Administrative Loss Ratio			*5.1%*	*6.6%*	*0.0%*	*4.8%*	*48.4%*	*5.2%*
Operating Income/(Loss)			**2,888,410**	**268,691**	**(7,349)**	**559,784**	**(56,347)**	**3,653,189**
Investments and Other Non-Operating			-					21,104,336
CHANGE IN NET ASSETS			**$ 2,888,410**	**$ 268,691**	**$ (7,349)**	**$ 559,784**	**$ (56,347)**	**$ 24,757,524**
BUDGETED CHANGE IN NET ASSETS			4,315,520	(2,278,271)	-	48,792	(73,182)	3,003,590
Variance to Budget - Fav/(Unfav)			$ (1,427,110)	$ 2,546,962	$ (7,349)	$ 510,992	$ 16,835	$ 21,753,935

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CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Five Months Ending November 30, 2023

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	2,999,574	1,792,195	4,791,769	88,751		2,186	2,491	4,882,706
REVENUES								
Capitation Revenue	$ 1,040,925,543	$ 759,650,604	$ 1,800,576,147	$ 161,389,845	$ (1,356,316)	$ 18,658,621	$ 1,065,043	$ 1,980,333,339
Total Operating Revenue	**1,040,925,543**	**759,650,604**	**1,800,576,147**	**161,389,845**	**(1,356,316)**	**18,658,621**	**1,065,043**	**1,980,333,339**
MEDICAL EXPENSES								
Provider Capitation	304,770,298	243,632,854	548,403,152	64,733,614				613,136,767
Claims	373,594,344	238,905,181	612,499,525	33,026,422	(1,828)	7,597,201		653,121,320
MLTSS	219,330,438	29,313,104	248,643,542	-	(19,416)	73,480	115,645	248,813,252
Prescription Drugs	(11,660)		(11,660)	43,941,621	(1,822,950)	2,359,658		44,466,669
Case Mgmt & Other Medical	139,655,535	96,801,404	236,456,939	7,096,204	86,200	5,638,319	757,911	250,035,573
Total Medical Expenses	**1,037,338,955**	**608,652,543**	**1,645,991,498**	**148,797,861**	**(1,757,995)**	**15,668,659**	**873,556**	**1,809,573,580**
Medical Loss Ratio	*99.7%*	*80.1%*	*91.4%*	*92.2%*	*129.6%*	*84.0%*	*82.0%*	*91.4%*
GROSS MARGIN	**3,586,588**	**150,998,061**	**154,584,649**	**12,591,983**	**401,678**	**2,989,962**	**191,487**	**170,759,759**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			53,934,818	4,955,044	(0)	797,430	469,963	60,157,255
Non-Salary Operating Expenses			10,656,889	1,488,581	(4,364)	43,751	6,692	12,191,549
Depreciation & Amortization			4,387,723			5,612		4,393,335
Other Operating Expenses			11,854,702	299,888		47,911	25,336	12,227,837
Indirect Cost Allocation, Occupancy			(2,578,831)	4,367,521		70,238	29,501	1,888,429
Total Administrative Expenses			**78,255,301**	**11,111,035**	**(4,364)**	**964,941**	**531,492**	**90,858,405**
Administrative Loss Ratio			*4.3%*	*6.9%*	*0.3%*	*5.2%*	*49.9%*	*4.6%*
Operating Income/(Loss)			**76,329,348**	**1,480,948**	**406,043**	**2,025,021**	**(340,005)**	**79,901,354**
Investments and Other Non-Operating			(830,003)					42,666,250
CHANGE IN NET ASSETS			**$ 75,499,344**	**$ 1,480,948**	**$ 406,043**	**$ 2,025,021**	**$ (340,005)**	**$ 122,567,605**
BUDGETED CHANGE IN NET ASSETS			26,955,875	(11,530,811)	-	269,490	(360,122)	458,086
Variance to Budget - Fav/(Unfav)			$ 48,543,469	$ 13,011,759	$ 406,043	$ 1,755,531	$ 20,117	$ 122,109,519

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CalOptima Health

Unaudited Financial Statements as of November 30, 2023

MONTHLY RESULTS:

- Change in Net Assets is $24.8 million, $21.8 million favorable to budget
- Operating surplus is $3.7 million, with a surplus in non-operating income of $21.1 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $122.6 million, $122.1 million favorable to budget
- Operating surplus is $79.9 million, with a surplus in non-operating income of $42.7 million

Change in Net Assets by Line of Business (LOB) ($ millions):

November 2023				July - November 2023		
Actual	**Budget**	**Variance**	**Operating Income (Loss)**	**Actual**	**Budget**	**Variance**
2.9	4.3	(1.4)	Medi-Cal	76.3	27.0	49.4
0.3	(2.3)	2.5	OneCare	1.5	(11.5)	13.0
(0.0)	0.0	(0.0)	OCC	0.4	0.0	0.4
0.6	0.0	0.5	PACE	2.0	0.3	1.8
(0.1)	(0.1)	0.0	MSSP	(0.3)	(0.4)	0.0
3.7	**2.0**	**1.6**	**Total Operating Income (Loss)**	**79.9**	**15.3**	**64.6**
			Non-Operating Income (Loss)			
21.1	2.1	19.0	Net Investment Income/Expense	72.5	10.4	62.0
(0.0)	(0.1)	0.1	Net Rental Income/Expense	0.0	(0.3)	0.3
0.0	0.0	0.0	Net Operating Tax	0.0	0.0	0.0
0.0	(1.0)	1.0	Grant Expense	(29.0)	(25.0)	(3.9)
0.0	0.0	0.0	Net QAF & IGT Income/Expense	0.0	0.0	0.0
0.0	0.0	0.0	Other Income/Expense	(0.8)	0.0	(0.8)
21.1	**1.0**	**20.1**	**Total Non-Operating Income/(Loss)**	**42.7**	**(14.9)**	**57.5**
24.8	**3.0**	**21.8**	**TOTAL**	**122.6**	**0.5**	**122.1**

CalOptima Health - Consolidated
Enrollment Summary
For the Five Months Ending November 30, 2023

November 2023					July - November 2023			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
144,153	138,420	5,733	4.1%	SPD	717,539	702,546	14,993	2.1%
296,211	308,781	(12,570)	(4.1%)	TANF Child	1,500,475	1,570,016	(69,541)	(4.4%)
138,904	125,558	13,346	10.6%	TANF Adult	710,030	650,627	59,403	9.1%
2,844	3,118	(274)	(8.8%)	LTC	14,623	15,590	(967)	(6.2%)
352,330	321,546	30,784	9.6%	MCE	1,792,195	1,711,786	80,409	4.7%
11,432	11,415	17	0.1%	WCM	56,907	56,935	(28)	(0.0%)
945,874	**908,838**	**37,036**	**4.1%**	**Medi-Cal Total**	**4,791,769**	**4,707,500**	**84,269**	**1.8%**
17,648	**17,799**	**(151)**	**(0.8%)**	**OneCare**	**88,751**	**88,500**	**251**	**0.3%**
446	**470**	**(24)**	**(5.1%)**	**PACE**	**2,186**	**2,308**	**(122)**	**(5.3%)**
491	**568**	**(77)**	**(13.6%)**	**MSSP**	**2,491**	**2,840**	**(349)**	**(12.3%)**
963,968	**927,107**	**36,861**	**4.0%**	**CalOptima Health Total**	**4,882,706**	**4,798,308**	**84,398**	**1.8%**
				Enrollment (by Network)				
264,162	262,789	1,373	0.5%	HMO	1,339,359	1,358,249	(18,890)	(1.4%)
186,968	175,205	11,763	6.7%	PHC	948,944	906,989	41,955	4.6%
226,826	214,358	12,468	5.8%	Shared Risk Group	1,160,828	1,127,482	33,346	3.0%
267,918	256,486	11,432	4.5%	Fee for Service	1,342,638	1,314,780	27,858	2.1%
945,874	**908,838**	**37,036**	**4.1%**	**Medi-Cal Total**	**4,791,769**	**4,707,500**	**84,269**	**1.8%**
17,648	**17,799**	**(151)**	**(0.8%)**	**OneCare**	**88,751**	**88,500**	**251**	**0.3%**
446	**470**	**(24)**	**(5.1%)**	**PACE**	**2,186**	**2,308**	**(122)**	**(5.3%)**
491	**568**	**(77)**	**(13.6%)**	**MSSP**	**2,491**	**2,840**	**(349)**	**(12.3%)**
963,968	**927,107**	**36,861**	**4.0%**	**CalOptima Health Total**	**4,882,706**	**4,798,308**	**84,398**	**1.8%**

Note:* Total membership does not include MSSP

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CalOptima Health
Enrollment Trend by Network
Fiscal Year 2024

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD Actual	YTD Budget	Variance
HMOs															
SPD	14,267	14,287	14,179	14,193	14,222								71,148	69,555	1,593
TANF Child	69,607	69,928	69,010	69,620	69,177								347,342	397,953	(50,611)
TANF Adult	50,979	51,388	50,896	50,392	49,538								253,193	248,470	4,723
LTC		1			(1)								0	0	0
MCE	132,523	133,978	131,301	130,441	129,207								657,450	631,107	26,343
WCM	2,050	2,095	2,021	2,041	2,019								10,226	11,164	(938)
Total	269,426	271,677	267,407	266,687	264,162								1,339,359	1,358,249	**(18,890)**
PHCs															
SPD	4,581	4,599	4,623	4,588	4,705								23,096	21,790	1,306
TANF Child	147,946	148,557	145,969	145,186	144,127								731,785	724,989	6,796
TANF Adult	8,999	9,050	9,404	8,885	8,692								45,030	16,315	28,715
LTC													0	0	0
MCE	23,230	23,489	22,708	22,540	22,400								114,367	109,782	4,585
WCM	6,919	6,974	6,900	6,829	7,044								34,666	34,113	553
Total	191,675	192,669	189,604	188,028	186,968								948,944	906,989	**41,955**
Shared Risk Groups															
SPD	11,210	11,137	11,111	10,982	10,833								55,273	55,328	(55)
TANF Child	55,211	55,471	54,427	53,505	52,934								271,548	291,042	(19,494)
TANF Adult	43,118	43,425	42,894	42,250	41,524								213,211	193,258	19,953
LTC	1	1			2								4	0	4
MCE	124,149	125,749	122,600	121,935	120,343								614,776	581,594	33,182
WCM	1,234	1,247	1,180	1,165	1,190								6,016	6,260	(244)
Total	**234,923**	**237,030**	**232,212**	**229,837**	**226,826**								**1,160,828**	**1,127,482**	**33,346**
Fee for Service (Dual)															
SPD	99,242	99,832	99,750	99,630	100,115								498,569	490,758	7,811
TANF Child													0	10	(10)
TANF Adult	2,442	2,397	2,370	2,307	2,247								11,763	11,918	(155)
LTC	2,661	2,630	2,612	2,492	2,525								12,920	13,740	(820)
MCE	8,968	9,230	9,418	9,312	9,117								46,045	46,169	(124)
WCM	15	14	14	13	13								69	90	(21)
Total	**113,328**	**114,103**	**114,164**	**113,754**	**114,017**								**569,366**	**562,685**	**6,681**
Fee for Service (Non-Dual - Total)															
SPD	13,519	13,778	13,957	13,921	14,278								69,453	65,115	4,338
TANF Child	29,143	30,159	31,025	29,500	29,973								149,800	156,022	(6,222)
TANF Adult	37,044	37,794	37,966	37,126	36,903								186,833	180,666	6,167
LTC	349	360	345	327	318								1,699	1,850	(151)
MCE	70,923	73,165	72,983	71,223	71,263								359,557	343,134	16,423
WCM	1,164	1,259	1,212	1,129	1,166								5,930	5,308	622
Total	**152,142**	**156,515**	**157,488**	**153,226**	**153,901**								**773,272**	**752,095**	**21,177**
Grand Totals															
SPD	142,819	143,633	143,620	143,314	144,153								717,539	702,546	14,993
TANF Child	301,907	304,115	300,431	297,811	296,211								1,500,475	1,570,016	(69,541)
TANF Adult	142,582	144,054	143,530	140,960	138,904								710,030	650,627	59,403
LTC	3,011	2,992	2,957	2,819	2,844								14,623	15,590	(967)
MCE	359,793	365,611	359,010	355,451	352,330								1,792,195	1,711,786	80,409
WCM	11,382	11,589	11,327	11,177	11,432								56,907	56,935	(28)
Total MediCal MM	**961,494**	**971,994**	**960,875**	**951,532**	**945,874**								**4,791,769**	**4,707,500**	**84,269**
OneCare	**17,695**	**17,815**	**17,836**	**17,757**	**17,648**								**88,751**	**88,500**	**251**
PACE	**429**	**432**	**437**	**442**	**446**								**2,186**	**2,308**	**(122)**
MSSP	**503**	**500**	**503**	**494**	**491**								**2,491**	**2,840**	**(349)**
Grand Total	**979,618**	**990,241**	**979,148**	**969,731**	**963,968**								**4,882,706**	**4,798,308**	**84,398**

Note:* Total membership does not include MSSP

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ENROLLMENT:

Overall, November enrollment was 963,968

- Favorable to budget 36,861 or 4.0%
- Decreased 5,763 or 0.6% from Prior Month (PM) (October 2023)
- Increased 20,370 or 2.2% from Prior Year (PY) (November 2022)

Medi-Cal enrollment was 945,874

- Favorable to budget 37,036 or 4.1% due to disenrollment being slower than originally anticipated based on the current economic conditions and expanded renewal outreach efforts
  - Medi-Cal Expansion (MCE) favorable 30,784
  - Seniors and Persons with Disabilities (SPD) favorable 5,733
  - Temporary Assistance for Needy Families (TANF) favorable 776
  - Whole Child Model (WCM) favorable 17
  - Long-Term Care (LTC) unfavorable 274
- Decreased 5,658 from PM

OneCare enrollment was 17,648

- Unfavorable to budget 151 or 0.8%
- Decreased 109 from PM

PACE enrollment was 446

- Unfavorable to budget 24 or 5.1%
- Increased 4 from PM

MSSP enrollment was 491

- Unfavorable to budget 77 or 13.6% due to MSSP currently being understaffed. There is a staff to member ratio that must be met
- Decreased 3 from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
945,874	**908,838**	**37,036**	**4.1%**	**Member Months**	**4,791,769**	**4,707,500**	**84,269**	**1.8%**
				Revenues				
326,873,824	304,063,525	22,810,299	7.5%	Medi-Cal Capitation Revenue	1,800,576,147	1,576,355,537	224,220,610	14.2%
326,873,824	**304,063,525**	**22,810,299**	**7.5%**	**Total Operating Revenue**	**1,800,576,147**	**1,576,355,537**	**224,220,610**	**14.2%**
				Medical Expenses				
102,686,514	101,196,794	(1,489,720)	(1.5%)	Provider Capitation	548,403,152	527,106,087	(21,297,065)	(4.0%)
70,627,649	71,145,822	518,173	0.7%	Facilities Claims	344,331,494	370,201,565	25,870,071	7.0%
55,865,537	44,159,577	(11,705,960)	(26.5%)	Professional Claims	268,168,031	230,055,185	(38,112,846)	(16.6%)
62,343,160	49,673,747	(12,669,413)	(25.5%)	MLTSS	248,643,542	255,117,791	6,474,249	2.5%
-	-	-	0.0%	Prescription Drugs	(11,660)	-	11,660	100.0%
8,460,607	6,814,807	(1,645,800)	(24.2%)	Incentive Payments	63,638,229	35,496,253	(28,141,976)	(79.3%)
6,708,998	7,619,263	910,265	11.9%	Medical Management	30,721,314	37,688,833	6,967,519	18.5%
708,315	1,017,524	309,209	30.4%	Other Medical Expenses	142,097,397	5,082,792	(137,014,605)	(2695.7%)
307,400,779	**281,627,534**	**(25,773,245)**	**(9.2%)**	**Total Medical Expenses**	**1,645,991,498**	**1,460,748,506**	**(185,242,992)**	**(12.7%)**
19,473,045	**22,435,991**	**(2,962,946)**	**(13.2%)**	**Gross Margin**	**154,584,649**	**115,607,031**	**38,977,618**	**33.7%**
				Administrative Expenses				
11,173,556	11,194,418	20,862	0.2%	Salaries, Wages & Employee Benefits	53,934,818	55,207,170	1,272,352	2.3%
954,017	1,092,058	138,041	12.6%	Professional Fees	2,994,018	4,952,435	1,958,417	39.5%
1,532,685	2,001,266	468,581	23.4%	Purchased Services	5,768,757	9,486,960	3,718,203	39.2%
283,059	412,310	129,251	31.3%	Printing & Postage	1,894,114	2,203,550	309,436	14.0%
859,144	400,000	(459,144)	(114.8%)	Depreciation & Amortization	4,387,723	2,000,000	(2,387,723)	(119.4%)
2,338,950	3,546,510	1,207,560	34.0%	Other Operating Expenses	11,854,702	17,431,496	5,576,794	32.0%
(556,777)	(526,091)	30,686	5.8%	Indirect Cost Allocation, Occupancy	(2,578,831)	(2,630,455)	(51,624)	(2.0%)
16,584,635	**18,120,471**	**1,535,836**	**8.5%**	**Total Administrative Expenses**	**78,255,301**	**88,651,156**	**10,395,855**	**11.7%**
				Non-Operating Income (Loss)				
-	-	-	0.0%	Other Income/Expense	(830,003)	-	(830,003)	(100.0%)
-	-	-	**0.0%**	**Total Non-Operating Income (Loss)**	**(830,003)**	-	**(830,003)**	**(100.0%)**
2,888,410	**4,315,520**	**(1,427,110)**	**(33.1%)**	**Change in Net Assets**	**75,499,345**	**26,955,875**	**48,543,470**	**180.1%**
94.0%	***92.6%***	***1.4%***		***Medical Loss Ratio***	***91.4%***	***92.7%***	***(1.3%)***	
5.1%	***6.0%***	***0.9%***		***Admin Loss Ratio***	***4.3%***	***5.6%***	***1.3%***	

MEDI-CAL INCOME STATEMENT– NOVEMBER MONTH:

REVENUES of $326.9 million are favorable to budget $22.8 million driven by:

- Favorable volume related variance of $12.4 million
- Favorable price related variance of $10.4 million
  - $7.4 million due to retroactive member months and favorable enrollment mix
  - $2.7 million due to net of COVID-19, Enhanced Care Management (ECM) and Proposition 56 risk corridor

MEDICAL EXPENSES of $307.4 million are unfavorable to budget $25.8 million driven by:

- Unfavorable volume related variance of $11.5 million
- Unfavorable price related variance of $14.3 million
  - Managed Long-Term Services and Supports (MLTSS) expense unfavorable variance of $10.6 million due to a true-up to the Department of Health Care Services (DHCS) newly released Calendar Year (CY) 2023 LTC rates
  - Professional Claims expense unfavorable variance of $9.9 million due Community Support (CS) services and Ground Emergency Medical Transportation (GEMT) related expenses higher than anticipated volume and rate
  - Incentive Payments expense unfavorable variance of $1.4 million
  - Offset by:
    - Facilities Claims expense favorable variance of $3.4 million
    - Provider Capitation expense favorable variance of $2.6 million
    - Medical Management expense favorable variance of $1.2 million

ADMINISTRATIVE EXPENSES of $16.6 million are favorable to budget $1.5 million driven by:

- Non-Salary expenses favorable to budget $1.5 million

CHANGE IN NET ASSETS is $2.9 million, unfavorable to budget $1.4 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
17,648	**17,799**	**(151)**	**(0.8%)**	**Member Months**	**88,751**	**88,500**	**251**	**0.3%**
				Revenues				
23,426,579	22,698,139	728,440	3.2%	Medicare Part C Revenue	116,606,715	113,697,969	2,908,746	2.6%
9,825,817	8,756,056	1,069,761	12.2%	Medicare Part D Revenue	44,783,130	43,572,061	1,211,069	2.8%
33,252,396	**31,454,195**	**1,798,201**	**5.7%**	**Total Operating Revenue**	**161,389,845**	**157,270,030**	**4,119,815**	**2.6%**
				Medical Expenses				
12,964,789	13,000,760	35,971	0.3%	Provider Capitation	64,733,614	65,125,188	391,574	0.6%
4,990,546	5,223,648	233,102	4.5%	Inpatient	25,850,767	26,012,786	162,019	0.6%
1,530,038	1,439,385	(90,653)	(6.3%)	Ancillary	7,175,655	7,275,335	99,680	1.4%
-	82,048	82,048	100.0%	MLTSS	-	407,983	407,983	100.0%
9,306,197	9,672,153	365,956	3.8%	Prescription Drugs	43,941,621	48,513,883	4,572,262	9.4%
834,437	375,315	(459,122)	(122.3%)	Incentive Payments	1,913,270	1,911,101	(2,169)	(0.1%)
1,148,990	1,271,087	122,097	9.6%	Medical Management	5,182,934	6,281,539	1,098,605	17.5%
30,774,997	**31,064,396**	**289,399**	**0.9%**	**Total Medical Expenses**	**148,797,861**	**155,527,815**	**6,729,954**	**4.3%**
2,477,399	**389,799**	**2,087,600**	**535.6%**	**Gross Margin**	**12,591,983**	**1,742,215**	**10,849,768**	**622.8%**
				Administrative Expenses				
1,006,636	1,174,971	168,335	14.3%	Salaries, Wages & Employee Benefits	4,955,044	5,807,531	852,487	14.7%
28,233	75,000	46,768	62.4%	Professional Fees	219,816	375,000	155,185	41.4%
151,236	268,942	117,706	43.8%	Purchased Services	752,819	1,332,710	579,891	43.5%
111,328	125,704	14,376	11.4%	Printing & Postage	515,947	628,520	112,573	17.9%
37,771	74,870	37,099	49.6%	Other Operating Expenses	299,888	386,350	86,462	22.4%
873,504	948,583	75,079	7.9%	Indirect Cost Allocation, Occupancy	4,367,521	4,742,915	375,394	7.9%
2,208,708	**2,668,070**	**459,362**	**17.2%**	**Total Administrative Expenses**	**11,111,035**	**13,273,026**	**2,161,991**	**16.3%**
268,691	**(2,278,271)**	**2,546,962**	**111.8%**	**Change in Net Assets**	**1,480,948**	**(11,530,811)**	**13,011,759**	**112.8%**
92.5%	***98.8%***	***(6.2%)***		***Medical Loss Ratio***	***92.2%***	***98.9%***	***(6.7%)***	
6.6%	***8.5%***	***1.8%***		***Admin Loss Ratio***	***6.9%***	***8.4%***	***1.6%***	

ONECARE INCOME STATEMENT– NOVEMBER MONTH:

REVENUES of $33.3 million are favorable to budget $1.8 million driven by:

- Unfavorable volume related variance of $0.3 million
- Favorable price related variance of $2.1 million

MEDICAL EXPENSES of $30.8 million are favorable to budget $0.3 million driven by:

- Favorable volume related variance of $0.3 million

ADMINISTRATIVE EXPENSES of $2.2 million are favorable to budget $0.5 million driven by:

- Non-Salary expenses favorable to budget $0.3 million
- Salaries & Benefit expense favorable to budget $0.2 million

CHANGE IN NET ASSETS is $0.3 million, favorable to budget $2.5 million

CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Five Months Ending November 30, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
-	-	-	0.0%	**Member Months**	-	-	-	0.0%
				Revenues				
10,810	-	10,810	100.0%	Medi-Cal Revenue	33,563	-	33,563	100.0%
-	-	-	0.0%	Medicare Part D Revenue	(1,389,879)	-	(1,389,879)	(100.0%)
10,810	**-**	**10,810**	**100.0%**	**Total Operating Revenue**	**(1,356,316)**	**-**	**(1,356,316)**	**(100.0%)**
				Medical Expenses				
(35,556)	-	35,556	100.0%	Facilities Claims	(429,085)	-	429,085	100.0%
60,094	-	(60,094)	(100.0%)	Ancillary	427,257	-	(427,257)	(100.0%)
(1,800)	-	1,800	100.0%	MLTSS	(19,416)	-	19,416	100.0%
-	-	-	0.0%	Prescription Drugs	(1,822,950)	-	1,822,950	100.0%
(4,579)	-	4,579	100.0%	Incentive Payments	86,200	-	(86,200)	(100.0%)
18,159	**-**	**(18,159)**	**(100.0%)**	**Total Medical Expenses**	**(1,757,995)**	**-**	**1,757,995**	**100.0%**
(7,349)	**-**	**(7,349)**	**(100.0%)**	**Gross Margin**	**401,678**	**-**	**401,678**	**100.0%**
				Administrative Expenses				
-	-	-	0.0%	Salaries, Wages & Employee Benefits	(0)	-	0	100.0%
-	-	-	0.0%	Purchased Services	(4,364)	-	4,364	100.0%
-	-	-	0.0%	Printing & Postage	0	-	(0)	(100.0%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**(4,364)**	**-**	**4,364**	**100.0%**
(7,349)	**-**	**(7,349)**	**(100.0%)**	**Change in Net Assets**	**406,043**	**-**	**406,043**	**100.0%**
168.0%	***0.0%***	***168.0%***		***Medical Loss Ratio***	***129.6%***	***0.0%***	***129.6%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.3%***	***0.0%***	***(0.3%)***	

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CalOptima Health
PACE
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
446	**470**	(24)	(5.1%)	**Member Months**	**2,186**	**2,308**	**(122)**	**(5.3%)**
				Revenues				
2,921,178	3,047,635	(126,457)	(4.1%)	Medi-Cal Capitation Revenue	14,261,893	14,966,987	(705,094)	(4.7%)
599,879	738,987	(139,108)	(18.8%)	Medicare Part C Revenue	3,114,422	3,679,893	(565,471)	(15.4%)
286,007	214,896	71,111	33.1%	Medicare Part D Revenue	1,282,306	1,053,990	228,316	21.7%
3,807,064	**4,001,518**	**(194,454)**	**(4.9%)**	**Total Operating Revenue**	**18,658,621**	**19,700,870**	**(1,042,249)**	**(5.3%)**
				Medical Expenses				
1,160,113	1,171,405	11,292	1.0%	Medical Management	5,638,319	5,800,135	161,816	2.8%
679,129	896,188	217,059	24.2%	Facilities Claims	3,233,035	4,469,045	1,236,010	27.7%
577,980	857,887	279,907	32.6%	Professional Claims	3,259,280	4,306,914	1,047,634	24.3%
467,722	460,238	(7,484)	(1.6%)	Prescription Drugs	2,359,658	2,270,728	(88,930)	(3.9%)
(37,932)	116,919	154,851	132.4%	MLTSS	73,480	589,865	516,385	87.5%
217,052	249,111	32,059	12.9%	Patient Transportation	1,104,886	999,895	(104,991)	(10.5%)
3,064,065	**3,751,748**	**687,684**	**18.3%**	**Total Medical Expenses**	**15,668,659**	**18,436,582**	**2,767,923**	**15.0%**
743,000	**249,770**	**493,230**	**197.5%**	**Gross Margin**	**2,989,962**	**1,264,288**	**1,725,674**	**136.5%**
				Administrative Expenses				
170,167	158,871	(11,296)	(7.1%)	Salaries, Wages & Employee Benefits	797,430	784,263	(13,167)	(1.7%)
-	4,904	4,904	100.0%	Professional Fees	1,879	24,520	22,641	92.3%
(10,101)	8,290	18,391	221.8%	Purchased Services	36,853	41,450	4,597	11.1%
1,514	4,112	2,598	63.2%	Printing & Postage	5,020	20,560	15,540	75.6%
1,118	900	(218)	(24.3%)	Depreciation & Amortization	5,612	4,500	(1,112)	(24.7%)
6,458	9,039	2,581	28.6%	Other Operating Expenses	47,911	45,195	(2,716)	(6.0%)
14,059	14,862	803	5.4%	Indirect Cost Allocation, Occupancy	70,238	74,310	4,072	5.5%
183,216	**200,978**	**17,762**	**8.8%**	**Total Administrative Expenses**	**964,941**	**994,798**	**29,857**	**3.0%**
559,784	**48,792**	**510,992**	**1047.3%**	**Change in Net Assets**	**2,025,021**	**269,490**	**1,755,531**	**651.4%**
80.5%	***93.8%***	***(13.3%)***		***Medical Loss Ratio***	***84.0%***	***93.6%***	***(9.6%)***	
4.8%	***5.0%***	***0.2%***		***Admin Loss Ratio***	***5.2%***	***5.0%***	***(0.1%)***	

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CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
491	**568**	**(77)**	**(13.6%)**	**Member Months**	**2,491**	**2,840**	**(349)**	**(12.3%)**
				Revenues				
213,144	253,518	(40,374)	(15.9%)	Revenue	1,065,043	1,267,590	(202,547)	(16.0%)
213,144	**253,518**	**(40,374)**	**(15.9%)**	**Total Operating Revenue**	**1,065,043**	**1,267,590**	**(202,547)**	**(16.0%)**
				Medical Expenses				
141,784	184,712	42,928	23.2%	Medical Management	757,911	923,560	165,649	17.9%
24,544	32,957	8,413	25.5%	Waiver Services	115,645	164,785	49,140	29.8%
141,784	184,712	42,928	23.2%	Total Medical Management	757,911	923,560	165,649	17.9%
24,544	32,957	8,413	25.5%	Total Waiver Services	115,645	164,785	49,140	29.8%
166,329	**217,669**	**51,340**	**23.6%**	**Total Program Expenses**	**873,556**	**1,088,345**	**214,789**	**19.7%**
46,815	**35,849**	**10,966**	**30.6%**	**Gross Margin**	**191,487**	**179,245**	**12,242**	**6.8%**
				Administrative Expenses				
89,539	92,730	3,191	3.4%	Salaries, Wages & Employee Benefits	469,963	457,862	(12,101)	(2.6%)
1,333	1,333	(0)	(0.0%)	Professional Fees	6,667	6,665	(2)	(0.0%)
2	-	(2)	(100.0%)	Purchased Services	25	-	(25)	(100.0%)
6,387	7,443	1,056	14.2%	Other Operating Expenses	25,336	37,215	11,879	31.9%
5,900	7,525	1,625	21.6%	Indirect Cost Allocation, Occupancy	29,501	37,625	8,124	21.6%
103,162	**109,031**	**5,869**	**5.4%**	**Total Administrative Expenses**	**531,492**	**539,367**	**7,875**	**1.5%**
(56,347)	**(73,182)**	**16,835**	**23.0%**	**Change in Net Assets**	**(340,005)**	**(360,122)**	**20,117**	**5.6%**
78.0%	***85.9%***	***(7.8%)***		***Medical Loss Ratio***	***82.0%***	***85.9%***	***(3.8%)***	
48.4%	***43.0%***	***(5.4%)***		***Admin Loss Ratio***	***49.9%***	***42.6%***	***(7.4%)***	

CalOptima Health
Building - 505 City Parkway
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
42,701	50,473	7,772	15.4%	Purchased Services	225,350	137,965	(87,385)	(63.3%)
177,525	211,000	33,475	15.9%	Depreciation & Amortization	887,624	1,055,000	167,376	15.9%
22,758	34,000	11,242	33.1%	Insurance Expense	113,791	170,000	56,209	33.1%
99,831	138,702	38,871	28.0%	Repair & Maintenance	598,307	807,910	209,603	25.9%
53,826	57,859	4,033	7.0%	Other Operating Expenses	344,930	289,295	(55,635)	(19.2%)
(396,641)	(492,034)	(95,393)	(19.4%)	Indirect Cost Allocation, Occupancy	(2,170,002)	(2,460,170)	(290,168)	(11.8%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

CalOptima Health
Building - 500 City Parkway
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
155,930	133,810	22,120	16.5%	Rental Income	786,203	669,050	117,153	17.5%
155,930	**133,810**	**22,120**	**16.5%**	**Total Operating Revenue**	**786,203**	**669,050**	**117,153**	**17.5%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
31,776	31,141	(635)	(2.0%)	Purchased Services	116,195	59,645	(56,550)	(94.8%)
34,573	40,000	5,427	13.6%	Depreciation & Amortization	172,865	200,000	27,135	13.6%
7,500	10,091	2,591	25.7%	Insurance Expense	37,502	50,455	12,953	25.7%
27,345	60,845	33,500	55.1%	Repair & Maintenance	225,032	400,285	175,253	43.8%
20,809	24,446	3,637	14.9%	Other Operating Expenses	151,955	122,230	(29,725)	(24.3%)
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
122,003	**166,523**	**44,520**	**26.7%**	**Total Administrative Expenses**	**703,549**	**832,615**	**129,066**	**15.5%**
33,927	**(32,713)**	**66,640**	**203.7%**	**Change in Net Assets**	**82,654**	**(163,565)**	**246,219**	**150.5%**

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CalOptima Health
Building - 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
-	56,667	56,667	100.0%	Purchased Services	6,966	113,334	106,368	93.9%
9,397	-	(9,397)	(100.0%)	Depreciation & Amortization	18,795	-	(18,795)	(100.0%)
8,829	-	(8,829)	(100.0%)	Insurance Expense	8,829	-	(8,829)	(100.0%)
36,480	-	(36,480)	(100.0%)	Repair & Maintenance	39,716	-	(39,716)	(100.0%)
2,430	-	(2,430)	(100.0%)	Other Operating Expenses	2,479	-	(2,479)	(100.0%)
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
57,136	**56,667**	**(469)**	**(0.8%)**	**Total Administrative Expenses**	**76,785**	**113,334**	**36,549**	**32.2%**
(57,136)	**(56,667)**	**(469)**	**(0.8%)**	**Change in Net Assets**	**(76,785)**	**(113,334)**	**36,549**	**32.2%**

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OTHER PROGRAM INCOME STATEMENTS – NOVEMBER MONTH:

ONECARE CONNECT

- **CHANGE IN NET ASSETS** is ($7,349), unfavorable to budget $7,349 due to prior year activities

PACE

- **CHANGE IN NET ASSETS** is $0.6 million, favorable to budget $0.5 million

MSSP

- **CHANGE IN NET ASSETS** is ($56,347), favorable to budget $16,835

NON-OPERATING INCOME STATEMENTS – NOVEMBER MONTH

BUILDING 500

- **CHANGE IN NET ASSETS** is $33,927, favorable to budget $66,640
  - Net of $0.2 million in rental income and $0.1 million in expenses

BUILDING 7900

- **CHANGE IN NET ASSETS** is ($57,136), unfavorable to budget $469

INVESTMENT INCOME

- Favorable variance of $19.0 million due to $11.1 million of interest income and $7.9 million realized and unrealized net gain on investments

CalOptima Health
Balance Sheet
November 30, 2023

		November-23	October-23	$ Change	% Change
ASSETS					
Current Assets					
	Cash and Cash Equivalents	787,560,580	791,125,217	(3,564,637)	(0.5%)
	Short-term Investments	1,682,516,212	1,682,326,188	190,023	0.0%
	Premiums due from State of CA and CMS	495,606,019	465,651,645	29,954,374	6.4%
	Prepaid Expenses and Other	15,093,584	14,985,598	107,986	0.7%
	Total Current Assets	**2,980,776,395**	**2,954,088,648**	**26,687,748**	**0.9%**
Board Designated Assets					
	Cash and Cash Equivalents	3,568,555	1,976,427	1,592,129	80.6%
	Investments	617,954,130	611,939,276	6,014,854	1.0%
	Total Board Designated Assets	**621,522,686**	**613,915,703**	**7,606,983**	**1.2%**
Restricted Deposit		**300,000**	**300,000**	**-**	**0.0%**
Capital Assets, Net		91,488,225	91,963,653	(475,428)	(0.5%)
Total Assets		**3,694,087,306**	**3,660,268,003**	**33,819,302**	**0.9%**
Deferred Outflows of Resources					
	Advance Discretionary Payment	49,999,717	49,999,717	-	0.0%
	Net Pension	24,373,350	24,373,350	-	0.0%
	Other Postemployment Benefits	1,596,000	1,596,000	-	0.0%
	Total Deferred Outflows of Resources	**75,969,067**	**75,969,067**	**-**	**0.0%**
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		**3,770,056,373**	**3,736,237,070**	**33,819,302**	**0.9%**
LIABILITIES					
Current Liabilities					
	Medical Claims Liability	1,677,619,379	1,667,742,576	9,876,803	0.6%
	Provider Capitation and Withholds	138,647,911	143,261,615	(4,613,703)	(3.2%)
	Accrued Reinsurance Costs to Providers	4,348,775	3,682,109	666,667	18.1%
	Unearned Revenue	35,139,960	33,586,916	1,553,044	4.6%
	Accounts Payable and Other	13,836,194	13,031,171	805,023	6.2%
	Accrued Payroll and Employee Benefits and Other	21,341,659	20,780,479	561,181	2.7%
	Deferred Lease Obligations	39,424	42,626	(3,202)	(7.5%)
	Total Current Liabilities	**1,890,973,303**	**1,882,127,491**	**8,845,812**	**0.5%**
	GASB 96 Subscription Liabilities	15,655,923	15,494,769	161,153	1.0%
	Postemployment Health Care Plan	19,212,627	19,157,815	54,812	0.3%
	Net Pension Liability	40,465,145	40,465,145	-	0.0%
Total Liabilities		**1,966,306,999**	**1,957,245,220**	**9,061,778**	**0.5%**
Deferred Inflows of Resources					
	Net Pension	3,387,516	3,387,516	-	0.0%
	Other Postemployment Benefits	7,788,000	7,788,000	-	0.0%
	Total Deferred Inflows of Resources	**11,175,516**	**11,175,516**	**-**	**0.0%**
Net Position					
	Required TNE	112,882,602	111,117,658	1,764,944	1.6%
	Funds in excess of TNE	1,679,691,256	1,656,698,676	22,992,580	1.4%
	Total Net Position	**1,792,573,858**	**1,767,816,334**	**24,757,524**	**1.4%**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION		**3,770,056,373**	**3,736,237,070**	**33,819,302**	**0.9%**

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BALANCE SHEET – NOVEMBER MONTH:

ASSETS of $3.8 billion increased $33.9 million from October or 0.9%

- Premiums due from the State of California (CA) and the Centers for Medicare & Medicaid Services (CMS) increased $30.0 million due to timing of cash receipts
- Total Board Designated Assets increased $7.6 million due to increased returns on investments driven by changes to interest rates and economy
- Operating Cash and Short-term Investments net decrease of $3.4 million

LIABILITIES of $2.0 billion increased $9.1 million from October or 0.5%

- Medical Claims Liabilities increased $9.9 million due to timing of claims payments
- Provider Capitation and Withholds decreased $4.6 million due to Proposition 56 estimates

NET ASSETS of $1.8 billion, increased $24.8 million from October or 1.4%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of November 30, 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	253,962,350				
	Tier 1 - MetLife	251,984,945				
Board Designated Reserve		505,947,294	360,495,474	563,371,792	145,451,821	(57,424,498)
	Tier 2 - Payden & Rygel	57,931,193				
	Tier 2 - MetLife	57,644,199				
TNE Requirement		115,575,391	112,882,602	112,882,602	2,692,789	2,692,789
	Consolidated:	**621,522,686**	**473,378,076**	**676,254,394**	**148,144,610**	**(54,731,709)**
	Current reserve level	*1.84*	*1.40*	*2.00*		

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CalOptima Health
Statement of Cash Flow
November 30, 2023

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	24,757,524	122,567,605
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation & Amortization	1,081,758	5,472,619
Changes in assets and liabilities:		
Prepaid expenses and other	(107,986)	(32,882)
Capitation receivable	(29,954,374)	(21,682,321)
Medical claims liability	10,543,470	41,729,390
Deferred revenue	1,553,044	(28,302,952)
Payable to health networks	(4,613,703)	13,203,886
Accounts payable	805,023	(1,245,749)
Accrued payroll	615,993	(1,753,104)
Other accrued liabilities	157,952	(467,677)
Net cash provided by/(used in) operating activities	4,838,699	129,488,815
GASB 68, GASB 75 and Advance Discretionary Payment Adjustments	-	(49,999,717)
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	(190,023)	(5,780,148)
Change in Property and Equipment	(606,330)	(12,753,339)
Change in Restricted Deposit & Other	-	-
Change in Board designated reserves	(7,606,983)	(44,970,992)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	(8,403,336)	(63,504,479)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(3,564,637)	15,984,619
CASH AND CASH EQUIVALENTS, beginning of period	$791,125,217	771,575,961
CASH AND CASH EQUIVALENTS, end of period	**787,560,580**	**787,560,580**

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CalOptima Health - Consolidated
Net Assets Analysis
For the Five Months Ending November 30, 2023

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 11/30/2023	**$1,792.6**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**621.5**			**34.7%**
	Capital Assets, net of Depreciation[2]	**91.5**			**5.1%**
Resources Allocated[3]	Homeless Health Initiative[4]	$18.7	$59.9	$41.2	1.0%
	Housing and Homelessness Initiative Program[4]	69.3	97.2	27.9	3.9%
	Intergovernmental Transfers (IGT)	58.5	111.7	53.2	3.3%
	Digital Transformation and Workplace Modernization	63.7	100.0	36.3	3.6%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	Outreach Strategy for CalFresh, Redetermination support, and other programs	6.1	8.0	1.9	0.3%
	Coalition of Orange County Community Health Centers Grant	30.0	50.0	20.0	1.7%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	0.7	1.0	0.3	0.0%
	General Awareness Campaign	0.7	2.7	2.0	0.0%
	Member Health Needs Assessment	0.8	1.0	0.2	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	146.4	153.5	7.1	8.2%
	Medi-Cal Annual Wellness Initiative	2.0	3.8	1.8	0.1%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.6%
	In-Home Care Pilot Program with the UCI Family Health Center	1.6	2.0	0.4	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	4.5	5.0	0.5	0.3%
	Community Living and PACE center (previously approved for project located in Tustin)	17.6	18.0	0.4	1.0%
	Stipend Program for Master of Social Work Students	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program	2.1	2.7	0.6	0.1%
	CalOptima Health Provider Workforce Development Fund	50.0	50.0	0.0	2.8%
	Distribution Event- Naloxone	2.5	15.0	12.5	0.1%
	Garden Grove Bldg Improvement	10.4	10.5	0.1	0.6%
	Post-Pandemic Supplemental	80.4	107.5	27.1	4.5%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	2.1%
	Subtotal:	**$614.1**	**$868.5**	**$254.4**	**34.3%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$465.4**			**26.0%**

[1] Total of Board Designated Reserve and unallocated reserve amount can support approximately 94 days of CalOptima Health's current operations
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements
[3] Initiatives that have been paid in full in the previous year are omitted from the list of Resources Allocated
[4] See HHI and HHIP summaries and Allocated Funds for list of Board approved initiatives

CalOptima Health
Key Financial Indicators
As of November 2023

	Item Name	Month-to-Date (Nov 2023)					FY 2024 Year-to-Date (Nov 2023)				
		Actual	Budget	Variance	%		Actual	Budget	Variance	%	
Income Statement	*Member Months*	963,968	927,107	36,861	4.0%		4,882,706	4,798,308	84,398	1.8%	
	Operating Revenue	364,157,238	339,772,756	24,384,482	7.2%		1,980,333,339	1,754,594,027	225,739,312	12.9%	
	Medical Expenses	341,424,329	316,661,347	(24,762,982)	(7.8%)		1,809,573,580	1,635,801,248	(173,772,332)	(10.6%)	
	General and Administrative Expense	19,079,720	21,098,550	2,018,830	9.6%		90,858,405	103,458,347	12,599,942	12.2%	
	Non-Operating Income/(Loss)	21,104,336	990,731	20,113,605	2,030.2%		42,666,250	(14,876,346)	57,542,596	386.8%	
	Summary of Income & Expenses	24,757,524	3,003,590	21,753,935	724.3%		122,567,605	458,086	122,109,519	26,656.4%	
Ratios	**Medical Loss Ratio (MLR)**	**Actual**	**Budget**	**Variance**			**Actual**	**Budget**	**Variance**		
	Consolidated	93.8%	93.2%	0.6%			91.4%	93.2%	(1.9%)		
	Administrative Loss Ratio (ALR)	**Actual**	**Budget**	**Variance**			**Actual**	**Budget**	**Variance**		
	Consolidated	5.2%	6.2%	1.0%			4.6%	5.9%	1.3%		

Key:

> 0%	
> -20%, < 0%	
< -20%	

Investment	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
	@11/30/2023	2,284,791,597	2,277,575,956	7,215,641	0.3%

Unallocated/Unassigned Reserve Balance	Current Month @ November 2023	Fiscal Year Ending June 2022	Change	%
Consolidated	465,433,909	354,771,258	110,662,651	31.2%
*Days Cash On Hand**	94			

*Total of Board Designated reserve and unallocated reserve amount can support approximatley 94 days of CalOptima Health's current operations.

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Five Months Ending November 30, 2023

	FY 2024 Month-to-Date				FY 2024 Year-to-Date				All Time to Date			
	Actual Spend	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**
Capital Assets (Cost, Information Only):												
Total Capital Assets	**396,581**	**1,836,414**	**1,439,833**	**78.4%**	**17,538,246**	**8,832,070**	**(8,706,176)**	**(98.6%)**	**21,136,297**	**45,678,070**	**24,541,773**	**53.7%**
Operating Expenses:												
Salaries, Wages & Benefits	640,138	609,649	(30,489)	(5.0%)	3,075,053	3,048,245	(26,808)	(0.9%)	6,493,630	8,340,478	1,846,848	22.1%
Professional Fees	295,000	192,916	(102,084)	(52.9%)	321,733	894,580	572,847	64.0%	587,926	3,027,080	2,439,154	80.6%
Purchased Services	200,000	155,000	(45,000)	(29.0%)	200,000	775,000	575,000	74.2%	200,000	1,085,000	885,000	81.6%
Other Expenses	969,175	1,371,009	401,834	29.3%	4,854,900	6,485,045	1,630,145	25.1%	7,869,677	9,877,425	2,007,748	20.3%
Total Operating Expenses	**2,104,313**	**2,328,574**	**224,261**	**9.6%**	**8,451,686**	**11,202,870**	**2,751,184**	**24.6%**	**15,151,232**	**22,329,983**	**7,178,751**	**32.1%**

Funding Balance Tracking:	**Actual Spend**	**Approved Budget**
Beginning Funding Balance	100,000,000	100,000,000
Less:		
FY2023	10,297,597	47,973,113
FY2024	25,989,932	49,189,899
FY2025		
Ending Funding Balance	**63,712,471**	**2,836,988**

Note: Report includes applicable transactions for GASB 96, Subscription.

CalOptima Health

Summary of Homeless Health Initiatives (HHI) and Allocated Funds

As of November 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 & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	662,709	300,552
FQHC (Community Health Center) Expansion	21,902	21,902	-
HCAP and CalOptima Health Days	9,888,914	3,170,400	6,718,514
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine	8,276,652	3,711,671	4,564,981
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[1]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$ 100,000,000**	**$ 41,203,732**	**$ 58,796,268**
Transfer of funds to HHIP[1]	(40,100,000)	-	(40,100,000)
Program Total	**$ 59,900,000**	**$ 41,203,732**	**$ 18,696,268**

Notes:

[1]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP.

CalOptima Health

Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds

As of November 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	382,200	417,800
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	1,461,149	2,560,162
Infrastructure Projects	5,832,314	2,785,365	3,046,949
Capital Projects	73,247,369	21,000,000	52,247,369
System Change Projects	10,180,000	-	10,180,000
Non-Profit Healthcare Academy	354,530	56,013	298,517
Total of Approved Initiatives	**$ 97,235,524** [1]	**$ 27,884,727**	**$ 69,350,798**

Notes:

[1]Total funding $97.2M: $40.1M Board-approved reallocation from HHI, $22.3M from CalOptima Health existing reserves and $34.8M from DHCS HHIP incentive payments

CalOptima Health
Budget Allocation Changes
Reporting Changes for November 2023

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	Purchased Services - TB Shots, Flu Shots, COVID Related Services & COVID Cleaning/Building Sanitization	Moving Services	$40,000	To repurpose from TB/Flu Shots and COVID Cleaning to provide more funding for Moving Services. ($16,000 from TB Shots, Flu Shots, COVID related services, $24,000 from COVID Cleaning/Building Sanitization)	2023-24
July	Medi-Cal	DTS Capital: I&O Internet Bandwidth	DTS Capital: I&O Network Bandwidth	$36,000	To reallocate funds from I&O Internet Bandwidth to I&O Network Bandwidth to cover shortage of fund for RFP.	2023-24
July	OneCare	Communication - Professional Fees Marketing/Advertising Agency Consulting	Community Relations - Membership Fees	$60,000	To reallocate funds from Communication – Professional Fees Marketing/Advertising Agency Consulting to Community Relations – Membership Fees to help fund E-Indicator Sponsorship bi-weekly newsletter.	2023-24
July	Medi-Cal	Corporate Application HR - Dayforce In-View	Corporate Application HR - SilkRoad OpenHire and Wingspan	$23,000	To reallocate funds from Corporate Application HR - Dayforce Inview to Corporate Application HR-SilkRoad OpenHire and Wingspan due to short of funds for renewal of contract.	2023-24
August	Medi-Cal	Quality Analytics – Other Operating Expenses - Incentives	Case Management – Other Operating Expenses - WPATH – Health Plan Provider Training	$24,500	To reallocate funding from Quality Analytics – Incentives to Case Management – WPATH – Health Plan Provider Training to provide funding for Blue Peak training.	2023-24
August	Medi-Cal	Quality Analytics - Other Operating Expenses - Incentives	Utilization Management – Purchased Services	$74,000	To reallocate funds from Quality Analytics – Incentives(MC) and Pharmacy Management – Professional Fees (OC) to Utilization Management – Purchased Services to provide funding for the Periscope Implementation.	2023-24
August	One Care	Pharmacy Management – Professional Fees	Utilization Management – Purchased Services	$15,000	To reallocate funds from Quality Analytics – Incentives(MC) and Pharmacy Management – Professional Fees (OC) to Utilization Management – Purchased Services to provide funding for the Periscope Implementation.	2023-24
August	Medi-Cal	Strategic Development - Professional Fees - DC Equity Consultant & Equity Initiative Activities	Strategic Development - Other Operating Expenses - Incentives	$67,000	To reallocate funds from Professional Fees – Equity Consultant, and Equity Initiative Activities to Purchased Services – Gift Cards to provide funding to purchase member incentive gift cards.	2023-24
September	One Care	Office of Compliance - Professional Fees - CPE Audit	Office of Compliance - Professional Fees - Blue Peak Services	$20,000	To reallocate funds from Professional Fees – CPE Audit to Professional Fees – Blue Peak Services to provide funding for Blue Peak Services.	2023-24
September	Medi-Cal	Customer Service - Member Communication – Maintenance of Business, Ad-Hoc/New Projects	Provider Data Mgmt Svcs – Purchased Services	$60,000	To reallocate funds from Customer Service – Member Communication Maintenance of Business and Ad-Hoc/New Projects to Provider Data Management Services – Purchased Services to provide funding for provider directory PDF Remediation services.	2023-24
September	Medi-Cal	Facilities - Audio Visual Enhancements	Facilities - CalOptima Health New Vehicle	$13,135	To reallocate funds from Facilities – Audio Visual Enhancements to Facilities – CalOptima Health New Vehicle for a new company vehicle.	2023-24
September	Medi-Cal	Medical Management – Other Operating Expenses – Training & Seminar	Behavioral Health Integration – Professional Fees	$16,000	To reallocate funds from Medical Management – Other Operating Expenses – Training & Seminar to Behavioral Health Integration – Professional Fees to provide funding for Autism Spectrum Therapies.	2023-24
September	Medi-Cal	Population Health Management – Purchased Services – Capacity Building Vendor	Population Health Management – Purchased Services – Capacity Building	$150,000	To repurpose funds from Purchased Services – Capacity Building Vendor to support the new Medi-Cal benefit, including incentives for contracting with CCN and delegated Health Networks, doula training, and technical assistance.	2023-24
September	Medi-Cal	IS – Enterprise Data & Sys Integration – Professional Fees	Enterprise Project Management Office – Professional Fees	$75,000	To reallocate funds from Enterprise Project Management Office – Training & Seminar, IS – Enterprise Data & Sys Integration – Professional Fees and IS – Application Development – Maintenance HW/SW to provide funding for the BCP consultation project.	2023-24
September	Medi-Cal	IS – Application Development – Maintenance HW/SW	Enterprise Project Management Office – Professional Fees	$55,000	To reallocate funds from Enterprise Project Management Office – Training & Seminar, IS – Enterprise Data & Sys Integration – Professional Fees and IS – Application Development – Maintenance HW/SW to provide funding for the BCP consultation project.	2023-24
October	Medi-Cal	DTS Capital: Migrate Data Warehouse / Analytics to the Cloud	DTS Capital: Enterprise Data Quality Enhancement	$140,000	To reallocate funds from AppDev – Migrate Data Warehouse Analytics to AppDev – Enterprise Data Quality Enhancement to help with Collibra Data Governance invoice.	2023-24
October	Medi-Cal	Medi-Cal/Claim - Other Operating Expenses - Food Service Supply	Medi-Cal/Claim - Other Operating Expenses - Travel	$16,000	To reallocate funds from Medi-Cal/Claim – Food Service Supply to Medi-Cal/Claim – Travel to provide funding for Center for Care Innovations.	2023-24
October	Medi-Cal	Is – Infrastructure – Other Operating Expenses – Maintenance HW/SW	Provider Data Management Services – Purchased Services	$54,000	To reallocate funds from IS – Infrastructure – Microsoft Enterprise License Agreement, Sales & Marketing – FMO OneCare Marketing Partnership and IS – Application Management – Enthrive to Provider Data Management Services to provide funding for the provider directory PDF remediation service.	2023-24
October	One Care	IS – Application Management – Maintenance HW/SW	Provider Data Management Services - Purchased Services	$24,000	To reallocate funds from IS – Infrastructure – Microsoft Enterprise License Agreement, Sales & Marketing – FMO OneCare Marketing Partnership and IS – Application Management – Enthrive to Provider Data Management Services to provide funding for the provider directory PDF remediation service.	2023-24
November	Medi-Cal	IS - Application Management - Maintenance HW/SW	Medical Management - Professional Fees	$100,000	To reallocate funds from IS-Applications Management - Maintenance HW/SW IBM WebSphere to Medical Management - Professional Fees to fund a consulting project.	2023-24
November	Medi-Cal	Executive Office - Professional Fees	Executive Office - Other Operating Expenses - Professional Dues	$28,000	To reallocate funds from Professional Fees to Professional Dues to pay for CCI Membership.	2023-24
November	Medi-Cal	Infrastructure - Misc. HW/SW Technology Equipment (New Hire Equip)	Infrastructure - HW/SW Maintenance (Palo Alto Firewall)	$84,000	To reallocate funds from Infrastructure Misc. HW/SW Technology Equipment (New Hire Equipment) to HW/SW Maintenance (Palo Alto Firewall) to help with shortage of funds due to contract is co-termed.	2023-24

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $250,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Financial Summary

December 31, 2023

Board of Directors Meeting
February 1, 2024

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: December 2023

December					July - December 2023			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
954,214	911,024	43,190	4.7%	Member Months	5,836,920	5,709,332	127,588	2.2%
388,535,659	334,244,580	54,291,079	16.2%	Revenues	2,368,868,998	2,088,838,607	280,030,391	13.4%
374,249,429	318,567,307	(55,682,122)	(17.5%)	Medical Expenses	2,183,823,010	1,954,368,555	(229,454,455)	(11.7%)
18,203,266	20,737,242	2,533,976	12.2%	Administrative Expenses	109,061,671	124,195,589	15,133,918	12.2%
(3,917,037)	(5,059,969)	1,142,932	22.6%	Operating Margin	75,984,318	10,274,463	65,709,855	639.5%
21,140,336	2,083,330	19,057,006	914.7%	Net Investment Income/Expense	93,596,457	12,499,980	81,096,477	648.8%
(20,841)	(89,380)	68,539	76.7%	Net Rental Income/Expense	(14,971)	(366,279)	351,308	95.9%
(506,723)	(1,003,219)	496,497	49.5%	Grant Expense	(29,472,461)	(26,019,316)	(3,453,145)	(13.3%)
-	-	-	0.0%	Other Income/Expense	(830,003)	-	(830,003)	(100.0%)
20,612,772	990,731	19,622,041	1,980.6%	Total Non-Operating Income (Loss)	63,279,022	(13,885,615)	77,164,637	555.7%
16,695,735	**(4,069,238)**	**20,764,974**	**510.3%**	**Change in Net Assets**	**139,263,340**	**(3,611,152)**	**142,874,492**	**3,956.5%**
96.3%	*95.3%*	*1.0%*		*Medical Loss Ratio*	*92.2%*	*93.6%*	*(1.4%)*	
4.7%	*6.2%*	*1.5%*		*Administrative Loss Ratio*	*4.6%*	*5.9%*	*1.3%*	
96.3%	*95.3%*	*1.0%*		**MLR (excluding Directed Payments)*	*91.7%*	*93.6%*	*(1.8%)*	
4.7%	*6.2%*	*1.5%*		**ALR (excluding Directed Payments)*	*4.9%*	*5.9%*	*1.1%*	

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CalOptima Health

Financial Highlights Notes: December 2023

- Notable events/items in December 2023
  - $39.6 million in CalAIM Incentive Payment Program (IPP) revenue received
  - $40.3 million of Housing and Homelessness Incentive Program (HHIP) funds disbursed
  - Monthly utilization for CalAIM Community Support (CS) services increases from $9.6 million in November to $12.6 million in December

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CalOptima Health

FY 2023-24: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) December 2023: $16.7 million, favorable to budget $20.8 million or 510.3% driven primarily net investment income
  - Year To Date (YTD) July - December 2023: $139.3 million, favorable to budget $142.9 million or 3,956.5% due to favorable performance and net investment income
- Enrollment
  - MTD: 954,214 members, favorable to budget 43,190 or 4.7%
  - YTD: 5,836,920 member months, favorable to budget 127,588 or 2.2%

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CalOptima Health

FY 2023-24: Management Summary (cont.)

- Revenue
  - MTD: $388.5 million, favorable to budget $54.3 million or 16.2% driven by the Medi-Cal (MC) Line of Business (LOB)
    - Due to CalAIM IPP from the Department of Health Care Services (DHCS) and favorable enrollment mix
  - YTD: $2,368.9 million, favorable to budget $280.0 million or 13.4%
    - Driven primarily by Calendar Year (CY) 2022 Hospital Directed Payments (DP), CalAIM IPP and favorable enrollment mix

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CalOptima Health

FY 2023-24: Management Summary (cont.)

- Medical Expenses
  - MTD: $374.2 million, unfavorable to budget $55.7 million or 17.5%
    - Incentive Payments expense unfavorable variance of $41.5 million due primarily to HHIP
    - Professional Claims expense unfavorable variance of $12.1 million due to volume, post Public Health Emergency (PHE) payments and CS services
  - YTD: $2,183.8 million, unfavorable to budget $229.5 million or 11.7%
    - Driven primarily by CY 2022 Hospital DP, post PHE payments, CS services and HHIP

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CalOptima Health

FY 2023-24: Management Summary (cont.)

- Administrative Expenses
  - MTD: $18.2 million, favorable to budget $2.5 million or 12.2%
  - YTD: $109.1 million, favorable to budget $15.1 million or 12.2%

- Non-Operating Income (Loss)
  - MTD: $20.6 million, favorable to budget $19.6 million or 1,980.6% due primarily to net investment income
  - YTD: $63.3 million, favorable to budget $77.2 million or 555.7% due primarily to net investment income

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CalOptima Health

FY 2023-24: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 96.3% (96.3% excluding DP), Budget 95.3%
  - YTD: Actual 92.2% (91.7% excluding DP), Budget 93.6%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 4.7% (4.7% excluding DP), Budget 6.2%
  - YTD: Actual 4.6% (4.9% excluding DP), Budget 5.9%

- Balance Sheet Ratios
  - Current ratio*: 1.6
  - Board Designated Reserve level: 1.83
  - Net-position: $1.8 billion, including required Tangible Net Equity (TNE) of $116.1 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: December 2023

December 2023					July - December 2023			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
144,855	137,378	7,477	5.4%	SPD	862,394	839,924	22,470	2.7%
294,200	306,287	(12,087)	(3.9%)	TANF Child	1,794,675	1,876,303	(81,628)	(4.4%)
135,991	123,274	12,717	10.3%	TANF Adult	846,021	773,901	72,120	9.3%
2,755	3,118	(363)	(11.6%)	LTC	17,378	18,708	(1,330)	(7.1%)
347,339	311,218	36,121	11.6%	MCE	2,139,534	2,023,004	116,530	5.8%
11,034	11,430	(396)	(3.5%)	WCM	67,941	68,365	(424)	(0.6%)
936,174	**892,705**	**43,469**	**4.9%**	**Medi-Cal Total**	**5,727,943**	**5,600,205**	**127,738**	**2.3%**
17,593	**17,845**	**(252)**	**(1.4%)**	**OneCare**	**106,344**	**106,345**	**(1)**	**(0.0%)**
447	**474**	**(27)**	**(5.7%)**	**PACE**	**2,633**	**2,782**	**(149)**	**(5.4%)**
494	**568**	**(74)**	**(13.0%)**	**MSSP**	**2,985**	**3,408**	**(423)**	**(12.4%)**
954,214	**911,024**	**43,190**	**4.7%**	**CalOptima Health Total**	**5,836,920**	**5,709,332**	**127,588**	**2.2%**

*CalOptima Health Total does not include MSSP

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CalOptima Health

Consolidated Revenue & Expenses: December 2023 MTD

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	588,835	347,339	936,174	17,593		447	494	954,214
REVENUES								
Capitation Revenue	$ 210,678,552	$ 144,549,616	$ 355,228,168	$ 28,828,524	$ (10,749)	$ 4,274,408	$ 215,307	$ 388,535,659
Total Operating Revenue	**210,678,552**	**144,549,616**	**355,228,168**	**28,828,524**	**(10,749)**	**4,274,408**	**215,307**	**388,535,659**
MEDICAL EXPENSES								
Provider Capitation	59,082,506	46,836,290	105,918,796	12,655,973				118,574,770
Claims	80,783,848	51,469,212	132,253,060	7,105,544	(7,671)	1,766,260		141,117,193
MLTSS	44,458,242	5,973,626	50,431,868		(1,265)	(15,581)	27,948	50,442,971
Prescription Drugs	-			2,303,607	8	449,892		2,753,507
Case Mgmt & Other Medical	37,095,166	22,483,762	59,578,927	588,075	(38,319)	1,100,272	132,035	61,360,990
Total Medical Expenses	**221,419,761**	**126,762,890**	**348,182,651**	**22,653,199**	**(47,247)**	**3,300,842**	**159,984**	**374,249,429**
Medical Loss Ratio	*105.1%*	*87.7%*	*98.0%*	*78.6%*	*439.6%*	*77.2%*	*74.3%*	*96.3%*
GROSS MARGIN	**(10,741,209)**	**17,786,726**	**7,045,517**	**6,175,325**	**36,498**	**973,566**	**55,324**	**14,286,229**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			10,332,383	922,026		157,959	96,501	11,508,869
Non-Salary Operating Expenses			2,371,379	426,705		344,433	1,335	3,143,853
Depreciation & Amortization			1,036,444			1,110		1,037,554
Other Operating Expenses			2,061,807	46,232		6,788	6,838	2,121,665
Indirect Cost Allocation, Occupancy			(757,774)	1,123,984		17,653	7,462	391,325
Total Administrative Expenses			**15,044,238**	**2,518,947**	**-**	**527,944**	**112,137**	**18,203,266**
Administrative Loss Ratio			*4.2%*	*8.7%*	*0.0%*	*12.4%*	*52.1%*	*4.7%*
Operating Income/(Loss)			**(7,998,722)**	**3,656,378**	**36,498**	**445,622**	**(56,813)**	**(3,917,037)**
Investments and Other Non-Operating			-					20,612,772
CHANGE IN NET ASSETS			**$ (7,998,722)**	**$ 3,656,378**	**$ 36,498**	**$ 445,622**	**$ (56,813)**	**$ 16,695,735**
BUDGETED CHANGE IN NET ASSETS			(2,082,044)	(2,794,488)	-	(111,911)	(71,526)	(4,069,238)
Variance to Budget - Fav/(Unfav)			$ (5,916,678)	$ 6,450,866	$ 36,498	$ 557,533	$ 14,713	$ 20,764,974

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CalOptima Health

Consolidated Revenue & Expenses: December 2023 YTD

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	3,588,409	2,139,534	5,727,943	106,344		2,633	2,985	5,836,920
REVENUES								
Capitation Revenue	$ 1,251,604,095	$ 904,200,220	$2,155,804,315	$ 190,218,369	$ (1,367,065)	$ 22,933,029	$ 1,280,350	$ 2,368,868,998
Total Operating Revenue	**1,251,604,095**	**904,200,220**	**2,155,804,315**	**190,218,369**	**(1,367,065)**	**22,933,029**	**1,280,350**	**2,368,868,998**
MEDICAL EXPENSES								
Provider Capitation	363,852,805	290,469,144	654,321,949	77,389,588				731,711,537
Claims	454,378,192	290,374,393	744,752,585	40,131,966	(9,499)	9,363,461		794,238,513
MLTSS	263,788,680	35,286,730	299,075,410	-	(20,680)	57,900	143,594	299,256,223
Prescription Drugs	(11,660)		(11,660)	46,245,227	(1,822,942)	2,809,550		47,220,175
Case Mgmt & Other Medical	176,750,701	119,285,166	296,035,866	7,684,279	47,880	6,738,591	889,946	311,396,563
Total Medical Expenses	**1,258,758,716**	**735,415,433**	**1,994,174,150**	**171,451,060**	**(1,805,241)**	**18,969,502**	**1,033,540**	**2,183,823,010**
Medical Loss Ratio	*100.6%*	*81.3%*	*92.5%*	*90.1%*	*132.1%*	*82.7%*	*80.7%*	*92.2%*
GROSS MARGIN	**(7,154,621)**	**168,784,787**	**161,630,165**	**18,767,309**	**438,176**	**3,963,528**	**246,810**	**185,045,989**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			64,267,201	5,877,070	(0)	955,389	566,464	71,666,124
Non-Salary Operating Expenses			13,028,268	1,915,286	(4,364)	388,184	8,027	15,335,402
Depreciation & Amortization			5,424,167			6,722		5,430,889
Other Operating Expenses			13,916,509	346,120		54,699	32,174	14,349,502
Indirect Cost Allocation, Occupancy			(3,336,606)	5,491,505		87,891	36,963	2,279,753
Total Administrative Expenses			**93,299,539**	**13,629,982**	**(4,364)**	**1,492,885**	**643,629**	**109,061,671**
Administrative Loss Ratio			*4.3%*	*7.2%*	*0.3%*	*6.5%*	*50.3%*	*4.6%*
Operating Income/(Loss)			**68,330,626**	**5,137,326**	**442,541**	**2,470,643**	**(396,818)**	**75,984,318**
Investments and Other Non-Operating			(830,003)					63,279,022
CHANGE IN NET ASSETS			**$ 67,500,623**	**$ 5,137,326**	**$ 442,541**	**$ 2,470,643**	**$ (396,818)**	**$ 139,263,340**
BUDGETED CHANGE IN NET ASSETS			24,873,831	(14,325,299)	-	157,579	(431,648)	(3,611,152)
Variance to Budget - Fav/(Unfav)			$ 42,626,792	$ 19,462,625	$ 442,541	$ 2,313,064	$ 34,830	$ 142,874,492

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CalOptima Health

Balance Sheet: As of December 2023

ASSETS	
Current Assets	
Operating Cash	$824,928,374
Short-term Investments	1,654,823,000
Receivables & Other Current Assets	473,960,060
Total Current Assets	**2,953,711,433**
Capital Assets	
Capital Assets	168,013,983
Less Accumulated Depreciation	(73,756,588)
Capital Assets, Net of Depreciation	94,257,396
Other Assets	
Restricted Deposits	300,000
Board Designated Reserve	629,263,837
Total Other Assets	**629,563,837**
TOTAL ASSETS	**3,677,532,665**
Deferred Outflows	**75,969,067**
TOTAL ASSETS & DEFERRED OUTFLOWS	**3,753,501,732**

LIABILITIES & NET POSITION	
Current Liabilities	
Accounts Payable	$15,311,331
Medical Claims Liability and Capitation Payable	1,676,468,920
Capitation and Withholds	127,263,602
Other Current Liabilities	36,659,268
Total Current Liabilities	**1,855,703,121**
Other Liabilities	
GASB 96 Subscription Liabilities	17,633,828
Postemployment Health Care Plan	19,254,529
Net Pension Liabilities	40,465,145
Total Other Liabilities	**77,353,503**
TOTAL LIABILITIES	**1,933,056,623**
Deferred Inflows	**11,175,516**
Net Position	
TNE	116,147,176
Funds in Excess of TNE	1,693,122,417
TOTAL NET POSITION	**1,809,269,593**
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**3,753,501,732**

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CalOptima Health

Board Designated Reserve and TNE Analysis: As of December 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	257,033,006				
	Tier 1 - MetLife	254,835,681				
Board Designated Reserve		511,868,687	364,181,101	570,036,077	147,687,586	(58,167,390)
	Tier 2 - Payden & Rygel	58,871,662				
	Tier 2 - MetLife	58,523,487				
TNE Requirement		117,395,149	116,147,176	116,147,176	1,247,973	1,247,973
	Consolidated:	**629,263,836**	**480,328,277**	**686,183,253**	**148,935,559**	**(56,919,417)**
	Current reserve level	*1.83*	*1.40*	*2.00*		

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CalOptima Health

Net Assets Analysis: As of December 2023

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 12/31/2023	**$1,809.3**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**629.3**			**34.8%**
	Capital Assets, net of Depreciation[2]	**94.3**			**5.2%**
Resources Allocated[3]	Homeless Health Initiative[4]	$18.4	$59.9	$41.5	1.0%
	Housing and Homelessness Incentive Program[4]	54.1	122.2	68.1	3.0%
	Intergovernmental Transfers (IGT)	58.3	111.7	53.4	3.2%
	Digital Transformation and Workplace Modernization	62.2	100.0	37.8	3.4%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	Outreach Strategy for CalFresh, Redetermination support, and other program	5.8	8.0	2.2	0.3%
	Coalition of Orange County Community Health Centers Grant	30.0	50.0	20.0	1.7%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	0.6	1.0	0.4	0.0%
	General Awareness Campaign	1.3	2.7	1.4	0.1%
	Member Health Needs Assessment	0.7	1.0	0.3	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	145.1	153.5	8.4	8.0%
	Medi-Cal Annual Wellness Initiative	2.0	3.8	1.8	0.1%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.6%
	In-Home Care Pilot Program with the UCI Family Health Center	1.5	2.0	0.5	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	4.0	5.0	1.0	0.2%
	Community Living and PACE center (previously approved for project located ir	17.6	18.0	0.4	1.0%
	Stipend Program for Master of Social Work Students	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program	2.1	2.7	0.6	0.1%
	CalOptima Health Provider Workforce Development Fund	50.0	50.0	0.0	2.8%
	Distribution Event- Naloxone	2.5	15.0	12.5	0.1%
	Garden Grove Bldg Improvement	10.4	10.5	0.1	0.6%
	Post-Pandemic Supplemental	66.4	107.5	41.1	3.7%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	2.1%
	Outreach Strategy for newly eligible Adult Expansion members	2.5	2.5	0.0	0.1%
	Quality Initiatives from unearned Pay for Value Program	23.3	23.3	0.0	1.3%
	Subtotal:	**$606.9**	**$919.3**	**$312.5**	**33.5%**
Resources Available for New Initiativ	Unallocated/Unassigned[1]	**$478.9**			**26.5%**

[1] Total of Board Designated Reserve and unallocated reserve amount can support approximately 95 days of CalOptima Health's current operations

[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements

[3] Initiatives that have been paid in full in the previous year are omitted from the list of Resources Allocated

[4] See HHI and HHIP summaries and Allocated Funds for list of Board approved initiatives

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CalOptima Health

Homeless Health Initiative and Allocated Funds: As of December 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 & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative	963,261	727,506	235,755
FQHC (Community Health Center) Expansion	21,902	21,902	-
HCAP and CalOptima Health Days	9,888,914	3,170,400	6,718,514
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine	8,276,652	3,907,116	4,369,536
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[1]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$ 100,000,000**	**$ 41,463,974**	**$ 58,536,026**
Transfer of funds to HHIP[1]	(40,100,000)	-	(40,100,000)
Program Total	**$ 59,900,000**	**$ 41,463,974**	**$ 18,436,026**

Notes:

[1]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 December 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	382,200	417,800
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	2,922,299	1,099,013
Infrastructure Projects	5,832,314	5,288,398	543,916
Capital Projects	98,247,369	57,300,000	40,947,369
System Change Projects	10,180,000	-	10,180,000
Non-Profit Healthcare Academy	354,530	56,013	298,517
Total of Approved Initiatives	**$122,235,524** [1]	**$ 68,148,910**	**$ 54,086,615**

Notes:

[1]Total funding $122.2M: $40.1M Board-approved reallocation from HHI, $47.2M from CalOptima Health existing reserves and $34.8M from DHCS HHIP incentive payments

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UNAUDITED FINANCIAL STATEMENTS

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CalOptima Health - Consolidated
Financial Highlights
For the Six Months Ending December 31, 2023

December 2023					July - December 2023			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
954,214	911,024	43,190	4.7%	Member Months	5,836,920	5,709,332	127,588	2.2%
388,535,659	334,244,580	54,291,079	16.2%	Revenues	2,368,868,998	2,088,838,607	280,030,391	13.4%
374,249,429	318,567,307	(55,682,122)	(17.5%)	Medical Expenses	2,183,823,010	1,954,368,555	(229,454,455)	(11.7%)
18,203,266	20,737,242	2,533,976	12.2%	Administrative Expenses	109,061,671	124,195,589	15,133,918	12.2%
(3,917,037)	**(5,059,969)**	**1,142,932**	**22.6%**	**Operating Margin**	**75,984,318**	**10,274,463**	**65,709,855**	**639.5%**
				Non-Operating Income (Loss)				
21,140,336	2,083,330	19,057,006	914.7%	Net Investment Income/Expense	93,596,457	12,499,980	81,096,477	648.8%
(20,841)	(89,380)	68,539	76.7%	Net Rental Income/Expense	(14,971)	(366,279)	351,308	95.9%
(506,723)	(1,003,219)	496,497	49.5%	Grant Expense	(29,472,461)	(26,019,316)	(3,453,145)	(13.3%)
-	-	-	0.0%	Other Income/Expense	(830,003)	-	(830,003)	(100.0%)
20,612,772	**990,731**	**19,622,041**	**1,980.6%**	**Total Non-Operating Income (Loss)**	**63,279,022**	**(13,885,615)**	**77,164,637**	**555.7%**
16,695,735	**(4,069,238)**	**20,764,974**	**510.3%**	**Change in Net Assets**	**139,263,340**	**(3,611,152)**	**142,874,492**	**3,956.5%**
96.3%	95.3%	1.0%		Medical Loss Ratio	92.2%	93.6%	(1.4%)	
4.7%	6.2%	1.5%		Administrative Loss Ratio	4.6%	5.9%	1.3%	
(1.0%)	(1.5%)	0.5%		Operating Margin Ratio	3.2%	0.5%	2.7%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
96.3%	95.3%	1.0%		*MLR (excluding Directed Payments)	91.7%	93.6%	(1.8%)	
4.7%	6.2%	1.5%		*ALR (excluding Directed Payments)	4.9%	5.9%	1.1%	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

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CalOptima Health - Consolidated
Full Time Employee Data
For the Six Months Ending December 31, 2023

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1,250	1,352	102
OneCare	182	197	15
PACE	105	112	7
MSSP	19	24	5
Total	1,557	1,684	127

Total FTE's YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	7,520	8,114	594
OneCare	1,095	1,182	87
PACE	624	614	(10)
MSSP	120	141	21
Total	9,359	10,051	692

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	749	660	(89)
OneCare	97	91	(6)
PACE	4	4	0
MSSP	26	24	(2)
Consolidated	613	541	(72)

MM per FTE YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	762	690	(72)
OneCare	97	90	(7)
PACE	4	5	1
MSSP	25	24	(1)
Consolidated	624	568	(56)

Open Positions			
	Total	Medical	Admin
Medi-Cal	87.00	35.25	51.75
OneCare	11.50	3.50	8.00
PACE	5.00	5.00	0.00
MSSP	3.00	3.00	0.00
Total	106.50	46.75	59.75

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses
For the One Month Ending December 31, 2023

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	954,214		911,024		43,190	
REVENUE						
Medi-Cal	$ 355,228,168	$ 379.45	$ 298,509,522	$ 334.39	$ 56,718,646	$ 45.06
OneCare	28,828,524	1,638.64	31,449,518	1,762.37	(2,620,994)	(123.73)
OneCare Connect	(10,749)		-		(10,749)	-
PACE	4,274,408	9,562.43	4,032,022	8,506.38	242,386	1,056.05
MSSP	215,307	435.85	253,518	446.33	(38,211)	(10.48)
Total Operating Revenue	388,535,659	407.18	334,244,580	366.89	54,291,079	40.29
MEDICAL EXPENSES						
Medi-Cal	348,182,651	371.92	282,796,545	316.79	(65,386,106)	(55.13)
OneCare	22,653,199	1,287.63	31,604,546	1,771.06	8,951,347	483.43
OneCare Connect	(47,247)				47,247	-
PACE	3,300,842	7,384.44	3,947,525	8,328.11	646,683	943.67
MSSP	159,984	323.85	218,691	385.02	58,707	61.17
Total Medical Expenses	374,249,429	392.21	318,567,307	349.68	(55,682,122)	(42.53)
GROSS MARGIN	14,286,229	14.97	15,677,273	17.21	(1,391,044)	(2.24)
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	11,508,869	12.06	12,253,968	13.45	745,099	1.39
Professional Fees	936,061	0.98	1,171,867	1.29	235,806	0.31
Purchased Services	1,504,272	1.58	2,284,926	2.51	780,654	0.93
Printing & Postage	703,520	0.74	539,269	0.59	(164,251)	(0.15)
Depreciation & Amortization	1,037,554	1.09	400,900	0.44	(636,654)	(0.65)
Other Expenses	2,121,665	2.22	3,641,433	4.00	1,519,768	1.78
Indirect Cost Allocation, Occupancy	391,325	0.41	444,879	0.49	53,554	0.08
Total Administrative Expenses	18,203,266	19.08	20,737,242	22.76	2,533,976	3.68
INCOME (LOSS) FROM OPERATIONS	(3,917,037)	(4.10)	(5,059,969)	(5.55)	1,142,932	1.45
INVESTMENT INCOME						
Interest Income	13,718,202	14.38	2,083,330	2.29	11,634,872	12.09
Realized Gain/(Loss) on Investments	5,939	0.01	-	-	5,939	0.01
Unrealized Gain/(Loss) on Investments	7,416,194	7.77	-	-	7,416,194	7.77
Total Investment Income	21,140,336	22.15	2,083,330	2.29	19,057,006	19.86
NET RENTAL INCOME	(20,841)	(0.02)	(89,380)	(0.10)	68,539	0.08
TOTAL GRANT EXPENSE	(506,723)	(0.53)	(1,003,219)	(1.10)	496,497	0.57
CHANGE IN NET ASSETS	**16,695,735**	**17.50**	**(4,069,238)**	**(4.47)**	**20,764,974**	**21.97**
MEDICAL LOSS RATIO	**96.3%**		**95.3%**		**1.0%**	
ADMINISTRATIVE LOSS RATIO	**4.7%**		**6.2%**		**1.5%**	

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CalOptima Health- Consolidated - Year to Date
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2023

	Actual		Budget		Variance	
	$	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
MEMBER MONTHS	5,836,920		5,709,332		127,588	
REVENUE						
Medi-Cal	$ 2,155,804,315	$ 376.37	$ 1,874,865,059	$ 334.79	$ 280,939,256	$ 41.58
OneCare	190,218,369	1,788.71	188,719,548	1,774.60	1,498,821	14.11
OneCare Connect	(1,367,065)		-		(1,367,065)	0.00
PACE	22,933,029	8,709.85	23,732,892	8,530.87	(799,863)	178.98
MSSP	1,280,350	428.93	1,521,108	446.33	(240,758)	(17.40)
Total Operating Revenue	2,368,868,998	405.84	2,088,838,607	365.86	280,030,391	39.98
MEDICAL EXPENSES						
Medi-Cal	1,994,174,150	348.15	1,743,545,051	311.34	(250,629,099)	(36.81)
OneCare	171,451,060	1,612.23	187,132,361	1,759.67	15,681,301	147.44
OneCare Connect	(1,805,241)				1,805,241	0.00
PACE	18,969,502	7,204.52	22,384,107	8,046.05	3,414,605	841.53
MSSP	1,033,540	346.24	1,307,036	383.52	273,496	37.28
Total Medical Expenses	2,183,823,010	374.14	1,954,368,555	342.31	(229,454,455)	(31.83)
GROSS MARGIN	185,045,989	31.70	134,470,052	23.55	50,575,937	8.15
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	71,666,124	12.28	74,510,794	13.05	2,844,670	0.77
Professional Fees	4,158,441	0.71	6,530,487	1.14	2,372,046	0.43
Purchased Services	8,058,361	1.38	13,146,046	2.30	5,087,685	0.92
Printing & Postage	3,118,600	0.53	3,391,899	0.59	273,299	0.06
Depreciation & Amortization	5,430,889	0.93	2,405,400	0.42	(3,025,489)	(0.51)
Other Expenses	14,349,502	2.46	21,541,689	3.77	7,192,187	1.31
Indirect Cost Allocation, Occupancy	2,279,753	0.39	2,669,274	0.47	389,521	0.08
Total Administrative Expenses	109,061,671	18.68	124,195,589	21.75	15,133,918	3.07
INCOME (LOSS) FROM OPERATIONS	75,984,318	13.02	10,274,463	1.80	65,709,855	11.22
INVESTMENT INCOME						
Interest Income	77,605,346	13.30	12,499,980	2.19	65,105,366	11.11
Realized Gain/(Loss) on Investments	(2,239,173)	(0.38)	-	0.00	(2,239,173)	(0.38)
Unrealized Gain/(Loss) on Investments	18,230,285	3.12	-	0.00	18,230,285	3.12
Total Investment Income	93,596,457	16.04	12,499,980	2.19	81,096,477	13.85
NET RENTAL INCOME	(14,971)	0.00	(366,279)	(0.06)	351,308	0.06
TOTAL GRANT EXPENSE	(29,472,461)	(5.05)	(26,019,316)	(4.56)	(3,453,145)	(0.49)
OTHER INCOME/EXPENSE	(830,003)	(0.14)	-	0.00	(830,003)	(0.14)
CHANGE IN NET ASSETS	**139,263,340**	**23.86**	**(3,611,152)**	**(0.63)**	**142,874,492**	**24.49**
MEDICAL LOSS RATIO	**92.2%**		**93.6%**		**(1.4%)**	
ADMINISTRATIVE LOSS RATIO	**4.6%**		**5.9%**		**1.3%**	

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CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending December 31, 2023

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	588,835	347,339	936,174	17,593		447	494	954,214
REVENUES								
Capitation Revenue	$ 210,678,552	$ 144,549,616	$ 355,228,168	$ 28,828,524	$ (10,749)	$ 4,274,408	$ 215,307	$ 388,535,659
Total Operating Revenue	**210,678,552**	**144,549,616**	**355,228,168**	**28,828,524**	**(10,749)**	**4,274,408**	**215,307**	**388,535,659**
MEDICAL EXPENSES								
Provider Capitation	59,082,506	46,836,290	105,918,796	12,655,973				118,574,770
Claims	80,783,848	51,469,212	132,253,060	7,105,544	(7,671)	1,766,260		141,117,193
MLTSS	44,458,242	5,973,626	50,431,868		(1,265)	(15,581)	27,948	50,442,971
Prescription Drugs	-			2,303,607	8	449,892		2,753,507
Case Mgmt & Other Medical	37,095,166	22,483,762	59,578,927	588,075	(38,319)	1,100,272	132,035	61,360,990
Total Medical Expenses	**221,419,761**	**126,762,890**	**348,182,651**	**22,653,199**	**(47,247)**	**3,300,842**	**159,984**	**374,249,429**
Medical Loss Ratio	*105.1%*	*87.7%*	*98.0%*	*78.6%*	*439.6%*	*77.2%*	*74.3%*	*96.3%*
GROSS MARGIN	**(10,741,209)**	**17,786,726**	**7,045,517**	**6,175,325**	**36,498**	**973,566**	**55,324**	**14,286,229**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			10,332,383	922,026		157,959	96,501	11,508,869
Non-Salary Operating Expenses			2,371,379	426,705		344,433	1,335	3,143,853
Depreciation & Amortization			1,036,444			1,110		1,037,554
Other Operating Expenses			2,061,807	46,232		6,788	6,838	2,121,665
Indirect Cost Allocation, Occupancy			(757,774)	1,123,984		17,653	7,462	391,325
Total Administrative Expenses			**15,044,238**	**2,518,947**	**-**	**527,944**	**112,137**	**18,203,266**
Administrative Loss Ratio			*4.2%*	*8.7%*	*0.0%*	*12.4%*	*52.1%*	*4.7%*
Operating Income/(Loss)			**(7,998,722)**	**3,656,378**	**36,498**	**445,622**	**(56,813)**	**(3,917,037)**
Investments and Other Non-Operating			-					20,612,772
CHANGE IN NET ASSETS			**$ (7,998,722)**	**$ 3,656,378**	**$ 36,498**	**$ 445,622**	**$ (56,813)**	**$ 16,695,735**
BUDGETED CHANGE IN NET ASSETS			(2,082,044)	(2,794,488)	-	(111,911)	(71,526)	(4,069,238)
Variance to Budget - Fav/(Unfav)			$ (5,916,678)	$ 6,450,866	$ 36,498	$ 557,533	$ 14,713	$ 20,764,974

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CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Six Months Ending December 31, 2023

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	3,588,409	2,139,534	5,727,943	106,344		2,633	2,985	5,836,920
REVENUES								
Capitation Revenue	$ 1,251,604,095	$ 904,200,220	$ 2,155,804,315	$ 190,218,369	$ (1,367,065)	$ 22,933,029	$ 1,280,350	$ 2,368,868,998
Total Operating Revenue	**1,251,604,095**	**904,200,220**	**2,155,804,315**	**190,218,369**	**(1,367,065)**	**22,933,029**	**1,280,350**	**2,368,868,998**
MEDICAL EXPENSES								
Provider Capitation	363,852,805	290,469,144	654,321,949	77,389,588				731,711,537
Claims	454,378,192	290,374,393	744,752,585	40,131,966	(9,499)	9,363,461		794,238,513
MLTSS	263,788,680	35,286,730	299,075,410	-	(20,680)	57,900	143,594	299,256,223
Prescription Drugs	(11,660)		(11,660)	46,245,227	(1,822,942)	2,809,550		47,220,175
Case Mgmt & Other Medical	176,750,701	119,285,166	296,035,866	7,684,279	47,880	6,738,591	889,946	311,396,563
Total Medical Expenses	**1,258,758,716**	**735,415,433**	**1,994,174,150**	**171,451,060**	**(1,805,241)**	**18,969,502**	**1,033,540**	**2,183,823,010**
Medical Loss Ratio	*100.6%*	*81.3%*	*92.5%*	*90.1%*	*132.1%*	*82.7%*	*80.7%*	*92.2%*
GROSS MARGIN	**(7,154,621)**	**168,784,787**	**161,630,165**	**18,767,309**	**438,176**	**3,963,528**	**246,810**	**185,045,989**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			64,267,201	5,877,070	(0)	955,389	566,464	71,666,124
Non-Salary Operating Expenses			13,028,268	1,915,286	(4,364)	388,184	8,027	15,335,402
Depreciation & Amortization			5,424,167			6,722		5,430,889
Other Operating Expenses			13,916,509	346,120		54,699	32,174	14,349,502
Indirect Cost Allocation, Occupancy			(3,336,606)	5,491,505		87,891	36,963	2,279,753
Total Administrative Expenses			**93,299,539**	**13,629,982**	**(4,364)**	**1,492,885**	**643,629**	**109,061,671**
Administrative Loss Ratio			*4.3%*	*7.2%*	*0.3%*	*6.5%*	*50.3%*	*4.6%*
Operating Income/(Loss)			**68,330,626**	**5,137,326**	**442,541**	**2,470,643**	**(396,818)**	**75,984,318**
Investments and Other Non-Operating			(830,003)					63,279,022
CHANGE IN NET ASSETS			**$ 67,500,623**	**$ 5,137,326**	**$ 442,541**	**$ 2,470,643**	**$ (396,818)**	**$ 139,263,340**
BUDGETED CHANGE IN NET ASSETS			24,873,831	(14,325,299)	-	157,579	(431,648)	(3,611,152)
Variance to Budget - Fav/(Unfav)			$ 42,626,792	$ 19,462,625	$ 442,541	$ 2,313,064	$ 34,830	$ 142,874,492

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CalOptima Health

Unaudited Financial Statements as of December 31, 2023

MONTHLY RESULTS:

- Change in Net Assets is $16.7 million, $20.8 million favorable to budget
- Operating deficit is $3.9 million, with a surplus in non-operating income of $20.6 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $139.3 million, $142.9 million favorable to budget
- Operating surplus is $76.0 million, with a surplus in non-operating income of $63.3 million

Change in Net Assets by Line of Business (LOB) ($ millions):

December 2023				July - December 2023		
Actual	**Budget**	**Variance**	**Operating Income (Loss)**	**Actual**	**Budget**	**Variance**
(8.0)	(2.1)	(5.9)	Medi-Cal	68.3	24.9	43.5
3.7	(2.8)	6.5	OneCare	5.1	(14.3)	19.5
0.0	0.0	0.0	OCC	0.4	0.0	0.4
0.4	(0.1)	0.6	PACE	2.5	0.2	2.3
(0.1)	(0.1)	0.0	MSSP	(0.4)	(0.4)	0.0
(3.9)	**(5.1)**	**1.1**	**Total Operating Income (Loss)**	**76.0**	**10.3**	**65.7**
			Non-Operating Income (Loss)			
21.1	2.1	19.1	Net Investment Income/Expense	93.6	12.5	81.1
(0.0)	(0.1)	0.1	Net Rental Income/Expense	(0.0)	(0.4)	0.4
0.0	0.0	0.0	Net Operating Tax	0.0	0.0	0.0
(0.5)	(1.0)	0.5	Grant Expense	(29.5)	(26.0)	(3.5)
0.0	0.0	0.0	Net QAF & IGT Income/Expense	0.0	0.0	0.0
0.0	0.0	0.0	Other Income/Expense	(0.8)	0.0	(0.8)
20.6	**1.0**	**19.6**	**Total Non-Operating Income/(Loss)**	**63.3**	**(13.9)**	**77.2**
16.7	**(4.1)**	**20.8**	**TOTAL**	**139.3**	**(3.6)**	**142.9**

CalOptima Health - Consolidated
Enrollment Summary
For the Six Months Ending December 31, 2023

December					July - December 2023			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
144,855	137,378	7,477	5.4%	SPD	862,394	839,924	22,470	2.7%
294,200	306,287	(12,087)	(3.9%)	TANF Child	1,794,675	1,876,303	(81,628)	(4.4%)
135,991	123,274	12,717	10.3%	TANF Adult	846,021	773,901	72,120	9.3%
2,755	3,118	(363)	(11.6%)	LTC	17,378	18,708	(1,330)	(7.1%)
347,339	311,218	36,121	11.6%	MCE	2,139,534	2,023,004	116,530	5.8%
11,034	11,430	(396)	(3.5%)	WCM	67,941	68,365	(424)	(0.6%)
936,174	**892,705**	**43,469**	**4.9%**	**Medi-Cal Total**	**5,727,943**	**5,600,205**	**127,738**	**2.3%**
17,593	**17,845**	**(252)**	**(1.4%)**	**OneCare**	**106,344**	**106,345**	**(1)**	**(0.0%)**
447	**474**	**(27)**	**(5.7%)**	**PACE**	**2,633**	**2,782**	**(149)**	**(5.4%)**
494	**568**	**(74)**	**(13.0%)**	**MSSP**	**2,985**	**3,408**	**(423)**	**(12.4%)**
954,214	**911,024**	**43,190**	**4.7%**	**CalOptima Health Total**	**5,836,920**	**5,709,332**	**127,588**	**2.2%**
				Enrollment (by Network)				
261,014	258,412	2,602	1.0%	HMO	1,600,373	1,616,661	(16,288)	(1.0%)
185,354	172,217	13,137	7.6%	PHC	1,134,298	1,079,206	55,092	5.1%
222,642	208,807	13,835	6.6%	Shared Risk Group	1,383,470	1,336,289	47,181	3.5%
267,164	253,269	13,895	5.5%	Fee for Service	1,609,802	1,568,049	41,753	2.7%
936,174	**892,705**	**43,469**	**4.9%**	**Medi-Cal Total**	**5,727,943**	**5,600,205**	**127,738**	**2.3%**
17,593	**17,845**	**(252)**	**(0)**	**OneCare**	**106,344**	**106,345**	**(1)**	**(0)**
447	**474**	**(27)**	**(5.7%)**	**PACE**	**2,633**	**2,782**	**(149)**	**(5.4%)**
494	**568**	**(74)**	**(13.0%)**	**MSSP**	**2,985**	**3,408**	**(423)**	**(12.4%)**
954,214	**911,024**	**43,190**	**4.7%**	**CalOptima Health Total**	**5,836,920**	**5,709,332**	**127,588**	**2.2%**

Note:* Total membership does not include MSSP

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2024

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD Actual	YTD Budget	Variance
HMOs															
SPD	14,267	14,287	14,179	14,193	14,222	14,337							85,485	82,997	2,488
TANF Child	69,607	69,928	69,010	69,620	69,177	68,696							416,038	477,385	(61,347)
TANF Adult	50,979	51,388	50,896	50,392	49,538	48,637							301,830	296,009	5,821
LTC		1			(1)	1							1		1
MCE	132,523	133,978	131,301	130,441	129,207	127,361							784,811	746,866	37,945
WCM	2,050	2,095	2,021	2,041	2,019	1,982							12,208	13,404	(1,196)
Total	269,426	271,677	267,407	266,687	264,162	261,014							1,600,373	1,616,661	**(16,288)**
PHCs															
SPD	4,581	4,599	4,623	4,588	4,705	4,770							27,866	25,999	1,867
TANF Child	147,946	148,557	145,969	145,186	144,127	143,149							874,934	863,288	11,646
TANF Adult	8,999	9,050	9,404	8,885	8,692	8,451							53,481	19,236	34,245
LTC													0		0
MCE	23,230	23,489	22,708	22,540	22,400	22,185							136,552	129,720	6,832
WCM	6,919	6,974	6,900	6,829	7,044	6,799							41,465	40,963	502
Total	191,675	192,669	189,604	188,028	186,968	185,354							1,134,298	1,079,206	**55,092**
Shared Risk Groups															
SPD	11,210	11,137	11,111	10,982	10,833	10,803							66,076	65,896	180
TANF Child	55,211	55,471	54,427	53,505	52,934	52,285							323,833	348,341	(24,508)
TANF Adult	43,118	43,425	42,894	42,250	41,524	40,564							253,775	229,233	24,542
LTC	1	1			2	2							6		6
MCE	124,149	125,749	122,600	121,935	120,343	117,859							732,635	685,303	47,332
WCM	1,234	1,247	1,180	1,165	1,190	1,129							7,145	7,516	(371)
Total	**234,923**	**237,030**	**232,212**	**229,837**	**226,826**	**222,642**							**1,383,470**	**1,336,289**	**47,181**
Fee for Service (Dual)															
SPD	99,242	99,832	99,750	99,630	100,115	100,302							598,871	587,378	11,493
TANF Child													0	12	(12)
TANF Adult	2,442	2,397	2,370	2,307	2,247	2,150							13,913	14,251	(338)
LTC	2,661	2,630	2,612	2,492	2,525	2,421							15,341	16,488	(1,147)
MCE	8,968	9,230	9,418	9,312	9,117	8,759							54,804	55,026	(222)
WCM	15	14	14	13	13	10							79	108	(29)
Total	**113,328**	**114,103**	**114,164**	**113,754**	**114,017**	**113,642**							**683,008**	**673,263**	**9,745**
Fee for Service (Non-Dual - Total)															
SPD	13,519	13,778	13,957	13,921	14,278	14,643							84,096	77,654	6,442
TANF Child	29,143	30,159	31,025	29,500	29,973	30,070							179,870	187,277	(7,407)
TANF Adult	37,044	37,794	37,966	37,126	36,903	36,189							223,022	215,172	7,850
LTC	349	360	345	327	318	331							2,030	2,220	(190)
MCE	70,923	73,165	72,983	71,223	71,263	71,175							430,732	406,089	24,643
WCM	1,164	1,259	1,212	1,129	1,166	1,114							7,044	6,374	670
Total	**152,142**	**156,515**	**157,488**	**153,226**	**153,901**	**153,522**							**926,794**	**894,786**	**32,008**
Grand Totals															
SPD	142,819	143,633	143,620	143,314	144,153	144,855							862,394	839,924	22,470
TANF Child	301,907	304,115	300,431	297,811	296,211	294,200							1,794,675	1,876,303	(81,628)
TANF Adult	142,582	144,054	143,530	140,960	138,904	135,991							846,021	773,901	72,120
LTC	3,011	2,992	2,957	2,819	2,844	2,755							17,378	18,708	(1,330)
MCE	359,793	365,611	359,010	355,451	352,330	347,339							2,139,534	2,023,004	116,530
WCM	11,382	11,589	11,327	11,177	11,432	11,034							67,941	68,365	(424)
Total MediCal MM	**961,494**	**971,994**	**960,875**	**951,532**	**945,874**	**936,174**							**5,727,943**	**5,600,205**	**127,738**
OneCare	**17,695**	**17,815**	**17,836**	**17,757**	**17,648**	**17,593**							**106,344**	**106,345**	**(1)**
PACE	**429**	**432**	**437**	**442**	**446**	**447**							**2,633**	**2,782**	**(149)**
MSSP	**503**	**500**	**503**	**494**	**491**	**494**							**2,985**	**3,408**	**(423)**
Grand Total	**979,618**	**990,241**	**979,148**	**969,731**	**963,968**	**954,214**							**5,836,920**	**5,709,332**	**127,588**

Note:* Total membership does not include MSSP

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ENROLLMENT:

Overall, December enrollment was 954,214

- Favorable to budget 43,190 or 4.7%
- Decreased 9,754 or 1.0% from Prior Month (PM) (November 2023)
- Increased 9,239 or 1.0% from Prior Year (PY) (December 2022)

Medi-Cal enrollment was 936,174

  - Favorable to budget 43,469 or 4.9% due to disenrollment being slower than originally anticipated based on the current economic conditions and expanded renewal outreach efforts
  - Medi-Cal Expansion (MCE) favorable 36,121
  - Seniors and Persons with Disabilities (SPD) favorable 7,477
  - Temporary Assistance for Needy Families (TANF) favorable 630
  - Whole Child Model (WCM) unfavorable 396
  - Long-Term Care (LTC) unfavorable 363
- Decreased 9,700 from PM

OneCare enrollment was 17,593

- Unfavorable to budget 252 or 1.4%
- Decreased 55 from PM

PACE enrollment was 447

- Unfavorable to budget 27 or 5.7%
- Increased 1 from PM

MSSP enrollment was 494

- Unfavorable to budget 74 or 13.0% due to MSSP currently being understaffed. There is a staff to member ratio that must be met
- Increased 3 from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
936,174	**892,705**	**43,469**	**4.9%**	**Member Months**	**5,727,943**	**5,600,205**	**127,738**	**2.3%**
				Revenues				
355,228,168	298,509,522	56,718,646	19.0%	Medi-Cal Capitation Revenue	2,155,804,315	1,874,865,059	280,939,256	15.0%
355,228,168	**298,509,522**	**56,718,646**	**19.0%**	**Total Operating Revenue**	**2,155,804,315**	**1,874,865,059**	**280,939,256**	**15.0%**
				Medical Expenses				
105,918,796	99,106,530	(6,812,266)	(6.9%)	Provider Capitation	654,321,949	626,212,617	(28,109,332)	(4.5%)
75,234,438	72,443,174	(2,791,264)	(3.9%)	Facilities Claims	419,565,932	442,644,739	23,078,807	5.2%
57,018,622	44,884,317	(12,134,305)	(27.0%)	Professional Claims	325,186,653	274,939,502	(50,247,151)	(18.3%)
50,431,868	51,146,456	714,588	1.4%	MLTSS	299,075,410	306,264,247	7,188,837	2.3%
-	-	-	0.0%	Prescription Drugs	(11,660)	-	11,660	100.0%
48,710,572	6,673,941	(42,036,631)	(629.9%)	Incentive Payments	112,348,801	42,170,194	(70,178,607)	(166.4%)
8,365,670	7,524,086	(841,584)	(11.2%)	Medical Management	39,086,984	45,212,919	6,125,935	13.5%
2,502,685	1,018,041	(1,484,644)	(145.8%)	Other Medical Expenses	144,600,082	6,100,833	(138,499,249)	(2270.2%)
348,182,651	**282,796,545**	**(65,386,106)**	**(23.1%)**	**Total Medical Expenses**	**1,994,174,150**	**1,743,545,051**	**(250,629,099)**	**(14.4%)**
7,045,517	**15,712,977**	**(8,667,460)**	**(55.2%)**	**Gross Margin**	**161,630,165**	**131,320,008**	**30,310,157**	**23.1%**
				Administrative Expenses				
10,332,383	10,863,254	530,871	4.9%	Salaries, Wages & Employee Benefits	64,267,201	66,070,424	1,803,223	2.7%
571,013	1,090,630	519,617	47.6%	Professional Fees	3,565,031	6,043,065	2,478,034	41.0%
1,202,601	2,008,408	805,807	40.1%	Purchased Services	6,971,358	11,495,368	4,524,010	39.4%
597,766	412,310	(185,456)	(45.0%)	Printing & Postage	2,491,880	2,615,860	123,980	4.7%
1,036,444	400,000	(636,444)	(159.1%)	Depreciation & Amortization	5,424,167	2,400,000	(3,024,167)	(126.0%)
2,061,807	3,546,510	1,484,703	41.9%	Other Operating Expenses	13,916,509	20,978,006	7,061,497	33.7%
(757,774)	(526,091)	231,683	44.0%	Indirect Cost Allocation, Occupancy	(3,336,606)	(3,156,546)	180,060	5.7%
15,044,238	**17,795,021**	**2,750,783**	**15.5%**	**Total Administrative Expenses**	**93,299,539**	**106,446,177**	**13,146,638**	**12.4%**
				Non-Operating Income (Loss)				
-	-	-	0.0%	Other Income/Expense	(830,003)	-	(830,003)	(100.0%)
(0)	-	**(0)**	**(100.0%)**	**Total Non-Operating Income (Loss)**	**(830,003)**	**-**	**(830,003)**	**(100.0%)**
(7,998,722)	**(2,082,044)**	**(5,916,678)**	**(284.2%)**	**Change in Net Assets**	**67,500,623**	**24,873,831**	**42,626,792**	**171.4%**
98.0%	***94.7%***	***3.3%***		***Medical Loss Ratio***	***92.5%***	***93.0%***	***(0.5%)***	
4.2%	***6.0%***	***1.7%***		***Admin Loss Ratio***	***4.3%***	***5.7%***	***1.3%***	

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MEDI-CAL INCOME STATEMENT– DECEMBER MONTH:

REVENUES of $355.2 million are favorable to budget $56.7 million driven by:

- Favorable volume related variance of $14.5 million
- Favorable price related variance of $42.2 million
  - $39.6 million due to CalAIM Incentive Payment Program (IPP) funding from the Department of Health Care Services (DHCS)
  - $7.2 million due to retroactive member months and favorable enrollment mix
  - Offset by:
  - $4.1 million from Enhanced Care Management (ECM) and Proposition 56 risk corridor

MEDICAL EXPENSES of $348.2 million are unfavorable to budget $65.4 million driven by:

- Unfavorable volume related variance of $13.8 million
- Unfavorable price related variance of $51.6 million
  - Incentive Payments expense unfavorable variance of $41.7 million due primarily to Housing and Homelessness Incentive Program (HHIP)
  - Professional Claims expense unfavorable variance of $9.9 million due primarily to Community Support (CS) services
  - Provider Capitation expense unfavorable variance of $2.0 million due to Board approved short-term Post Pandemic supplemental
  - Other Medical Expense unfavorable variance of $1.4 million due to PY reinsurance expenses
  - Offset by:
    •Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $3.2 million

ADMINISTRATIVE EXPENSES of $15.0 million are favorable to budget $2.8 million driven by:

- Non-Salary expenses favorable to budget $2.2 million
- Salary, Wages & Employee Benefits expense favorable to budget $0.5 million

CHANGE IN NET ASSETS is ($8.0) million, unfavorable to budget $5.9 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
17,593	**17,845**	**(252)**	**(1.4%)**	**Member Months**	**106,344**	**106,345**	**(1)**	**(0.0%)**
				Revenues				
22,768,654	22,673,924	94,730	0.4%	Medicare Part C Revenue	139,375,369	136,371,893	3,003,476	2.2%
6,059,870	8,775,594	(2,715,724)	(30.9%)	Medicare Part D Revenue	50,842,999	52,347,655	(1,504,656)	(2.9%)
28,828,524	**31,449,518**	**(2,620,994)**	**(8.3%)**	**Total Operating Revenue**	**190,218,369**	**188,719,548**	**1,498,821**	**0.8%**
				Medical Expenses				
12,655,973	12,986,712	330,739	2.5%	Provider Capitation	77,389,588	78,111,900	722,312	0.9%
5,556,389	5,425,187	(131,202)	(2.4%)	Inpatient	31,407,157	31,437,973	30,816	0.1%
1,549,154	1,493,048	(56,106)	(3.8%)	Ancillary	8,724,809	8,768,383	43,574	0.5%
-	82,264	82,264	100.0%	MLTSS	-	490,247	490,247	100.0%
2,303,607	10,067,776	7,764,169	77.1%	Prescription Drugs	46,245,227	58,581,659	12,336,432	21.1%
(198,313)	311,965	510,278	163.6%	Incentive Payments	1,714,957	2,223,066	508,109	22.9%
786,387	1,237,594	451,207	36.5%	Medical Management	5,969,322	7,519,133	1,549,811	20.6%
22,653,199	**31,604,546**	**8,951,347**	**28.3%**	**Total Medical Expenses**	**171,451,060**	**187,132,361**	**15,681,301**	**8.4%**
6,175,325	**(155,028)**	**6,330,353**	**4083.4%**	**Gross Margin**	**18,767,309**	**1,587,187**	**17,180,122**	**1082.4%**
				Administrative Expenses				
922,026	1,146,361	224,335	19.6%	Salaries, Wages & Employee Benefits	5,877,070	6,953,892	1,076,822	15.5%
50,028	75,000	24,972	33.3%	Professional Fees	269,843	450,000	180,157	40.0%
274,501	268,228	(6,273)	(2.3%)	Purchased Services	1,027,320	1,600,938	573,618	35.8%
102,177	122,847	20,670	16.8%	Printing & Postage	618,123	751,367	133,244	17.7%
46,232	78,441	32,209	41.1%	Other Operating Expenses	346,120	464,791	118,671	25.5%
1,123,984	948,583	(175,401)	(18.5%)	Indirect Cost Allocation, Occupancy	5,491,505	5,691,498	199,993	3.5%
2,518,947	**2,639,460**	**120,513**	**4.6%**	**Total Administrative Expenses**	**13,629,982**	**15,912,486**	**2,282,504**	**14.3%**
3,656,378	**(2,794,488)**	**6,450,866**	**230.8%**	**Change in Net Assets**	**5,137,326**	**(14,325,299)**	**19,462,625**	**135.9%**
78.6%	***100.5%***	***(21.9%)***		***Medical Loss Ratio***	***90.1%***	***99.2%***	***(9.0%)***	
8.7%	***8.4%***	***(0.3%)***		***Admin Loss Ratio***	***7.2%***	***8.4%***	***1.3%***	

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ONECARE INCOME STATEMENT– DECEMBER MONTH:

REVENUES of $28.8 million are unfavorable to budget $2.6 million driven by:

- Unfavorable volume related variance of $0.4 million
- Unfavorable price related variance of $2.2 million primarily due to Calendar Year (CY) 2023 Part D payment reconciliation

MEDICAL EXPENSES of $22.7 million are favorable to budget $9.0 million driven by:

- Favorable volume related variance of $0.4 million
- Favorable price variance of $8.5 million due to higher than estimated prescription rebates received

ADMINISTRATIVE EXPENSES of $2.5 million are favorable to budget $0.1 million driven by:

- Salaries, Wages & Employee Benefits expense favorable to budget $0.2 million
- Non-Salary expenses unfavorable to budget $0.1 million

CHANGE IN NET ASSETS is $3.7 million, favorable to budget $6.5 million

CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Six Months Ending December 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
-	-	-	0.0%	**Member Months**	-	-	-	0.0%
				Revenues				
(10,810)	-	(10,810)	(100.0%)	Medi-Cal Revenue	22,753	-	22,753	100.0%
61	-	61	100.0%	Medicare Part D Revenue	(1,389,817)	-	(1,389,817)	(100.0%)
(10,749)	**-**	**(10,749)**	**(100.0%)**	**Total Operating Revenue**	**(1,367,065)**	**-**	**(1,367,065)**	**(100.0%)**
				Medical Expenses				
(63,566)	-	63,566	100.0%	Facilities Claims	(492,651)	-	492,651	100.0%
55,895	-	(55,895)	(100.0%)	Ancillary	483,152	-	(483,152)	(100.0%)
(1,265)	-	1,265	100.0%	MLTSS	(20,680)	-	20,680	100.0%
8	-	(8)	(100.0%)	Prescription Drugs	(1,822,942)	-	1,822,942	100.0%
14,282	-	(14,282)	(100.0%)	Incentive Payments	100,482	-	(100,482)	(100.0%)
(52,602)	-	52,602	100.0%	Medical Management	(52,602)	-	52,602	100.0%
(47,247)	**-**	**47,247**	**100.0%**	**Total Medical Expenses**	**(1,805,241)**	**-**	**1,805,241**	**100.0%**
36,498	**-**	**36,498**	**100.0%**	**Gross Margin**	**438,176**	**-**	**438,176**	**100.0%**
				Administrative Expenses				
-	-	-	0.0%	Purchased Services	(4,364)	-	4,364	100.0%
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**(4,364)**	**-**	**4,364**	**100.0%**
36,498	**-**	**36,498**	**100.0%**	**Change in Net Assets**	**442,541**	**-**	**442,541**	**100.0%**
439.6%	***0.0%***	***439.6%***		***Medical Loss Ratio***	***132.1%***	***0.0%***	***132.1%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.3%***	***0.0%***	***(0.3%)***	

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CalOptima Health
PACE
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
447	**474**	(27)	(5.7%)	**Member Months**	**2,633**	**2,782**	**(149)**	**(5.4%)**
				Revenues				
2,942,026	3,073,922	(131,896)	(4.3%)	Medi-Cal Capitation Revenue	17,203,919	18,040,909	(836,990)	(4.6%)
1,087,370	740,955	346,415	46.8%	Medicare Part C Revenue	4,201,792	4,420,848	(219,056)	(5.0%)
245,013	217,145	27,868	12.8%	Medicare Part D Revenue	1,527,319	1,271,135	256,184	20.2%
4,274,408	**4,032,022**	**242,386**	**6.0%**	**Total Operating Revenue**	**22,933,029**	**23,732,892**	**(799,863)**	**(3.4%)**
				Medical Expenses				
1,100,272	1,254,516	154,244	12.3%	Medical Management	6,738,591	7,054,651	316,060	4.5%
776,876	936,305	159,429	17.0%	Facilities Claims	4,009,911	5,405,350	1,395,439	25.8%
724,097	889,280	165,183	18.6%	Professional Claims	3,983,378	5,196,194	1,212,816	23.3%
449,892	483,324	33,432	6.9%	Prescription Drugs	2,809,550	2,754,052	(55,498)	(2.0%)
(15,581)	122,092	137,673	112.8%	MLTSS	57,900	711,957	654,057	91.9%
265,287	262,008	(3,279)	(1.3%)	Patient Transportation	1,370,172	1,261,903	(108,269)	(8.6%)
3,300,842	**3,947,525**	**646,683**	**16.4%**	**Total Medical Expenses**	**18,969,502**	**22,384,107**	**3,414,605**	**15.3%**
973,566	**84,497**	**889,069**	**1052.2%**	**Gross Margin**	**3,963,528**	**1,348,785**	**2,614,743**	**193.9%**
				Administrative Expenses				
157,959	154,301	(3,658)	(2.4%)	Salaries, Wages & Employee Benefits	955,389	938,564	(16,825)	(1.8%)
313,688	4,904	(308,784)	(6296.6%)	Professional Fees	315,566	29,424	(286,142)	(972.5%)
27,168	8,290	(18,878)	(227.7%)	Purchased Services	64,021	49,740	(14,281)	(28.7%)
3,577	4,112	535	13.0%	Printing & Postage	8,597	24,672	16,075	65.2%
1,110	900	(210)	(23.4%)	Depreciation & Amortization	6,722	5,400	(1,322)	(24.5%)
6,788	9,039	2,251	24.9%	Other Operating Expenses	54,699	54,234	(465)	(0.9%)
17,653	14,862	(2,791)	(18.8%)	Indirect Cost Allocation, Occupancy	87,891	89,172	1,281	1.4%
527,944	**196,408**	**(331,536)**	**(168.8%)**	**Total Administrative Expenses**	**1,492,885**	**1,191,206**	**(301,679)**	**(25.3%)**
445,622	**(111,911)**	**557,533**	**498.2%**	**Change in Net Assets**	**2,470,643**	**157,579**	**2,313,064**	**1467.9%**
77.2%	***97.9%***	***(20.7%)***		***Medical Loss Ratio***	***82.7%***	***94.3%***	***(11.6%)***	
12.4%	***4.9%***	***(7.5%)***		***Admin Loss Ratio***	***6.5%***	***5.0%***	***(1.5%)***	

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CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
494	**568**	**(74)**	**(13.0%)**	**Member Months**	**2,985**	**3,408**	**(423)**	**(12.4%)**
				Revenues				
215,307	253,518	(38,211)	(15.1%)	Revenue	1,280,350	1,521,108	(240,758)	(15.8%)
215,307	**253,518**	**(38,211)**	**(15.1%)**	**Total Operating Revenue**	**1,280,350**	**1,521,108**	**(240,758)**	**(15.8%)**
				Medical Expenses				
132,035	185,734	53,699	28.9%	Medical Management	889,946	1,109,294	219,348	19.8%
27,948	32,957	5,009	15.2%	Waiver Services	143,594	197,742	54,149	27.4%
132,035	185,734	53,699	28.9%	Total Medical Management	889,946	1,109,294	219,348	19.8%
27,948	32,957	5,009	15.2%	Total Waiver Services	143,594	197,742	54,149	27.4%
159,984	**218,691**	**58,707**	**26.8%**	**Total Program Expenses**	**1,033,540**	**1,307,036**	**273,496**	**20.9%**
55,324	**34,827**	**20,497**	**58.9%**	**Gross Margin**	**246,810**	**214,072**	**32,738**	**15.3%**
				Administrative Expenses				
96,501	90,052	(6,449)	(7.2%)	Salaries, Wages & Employee Benefits	566,464	547,914	(18,550)	(3.4%)
1,333	1,333	(0)	(0.0%)	Professional Fees	8,000	7,998	(2)	(0.0%)
2	-	(2)	(100.0%)	Purchased Services	27	-	(27)	(100.0%)
6,838	7,443	605	8.1%	Other Operating Expenses	32,174	44,658	12,484	28.0%
7,462	7,525	63	0.8%	Indirect Cost Allocation, Occupancy	36,963	45,150	8,187	18.1%
112,137	**106,353**	**(5,784)**	**(5.4%)**	**Total Administrative Expenses**	**643,629**	**645,720**	**2,091**	**0.3%**
(56,813)	**(71,526)**	**14,713**	**20.6%**	**Change in Net Assets**	**(396,818)**	**(431,648)**	**34,830**	**8.1%**
74.3%	***86.3%***	***(12.0%)***		***Medical Loss Ratio***	***80.7%***	***85.9%***	***(5.2%)***	
52.1%	***42.0%***	***(10.1%)***		***Admin Loss Ratio***	***50.3%***	***42.5%***	***(7.8%)***	

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CalOptima Health
Building - 505 City Parkway
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
46,497	50,473	3,976	7.9%	Purchased Services	271,847	188,438	(83,409)	(44.3%)
178,825	211,000	32,175	15.2%	Depreciation & Amortization	1,066,449	1,266,000	199,551	15.8%
22,758	34,000	11,242	33.1%	Insurance Expense	136,550	204,000	67,450	33.1%
170,468	138,702	(31,766)	(22.9%)	Repair & Maintenance	768,774	946,612	177,838	18.8%
56,202	57,859	1,657	2.9%	Other Operating Expenses	401,132	347,154	(53,978)	(15.5%)
(474,750)	(492,034)	(17,284)	(3.5%)	Indirect Cost Allocation, Occupancy	(2,644,752)	(2,952,204)	(307,452)	(10.4%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

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CalOptima Health
Building - 500 City Parkway
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
156,423	133,810	22,613	16.9%	Rental Income	942,627	802,860	139,767	17.4%
156,423	**133,810**	**22,613**	**16.9%**	**Total Operating Revenue**	**942,627**	**802,860**	**139,767**	**17.4%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
31,121	31,141	20	0.1%	Purchased Services	147,317	90,786	(56,531)	(62.3%)
34,573	40,000	5,427	13.6%	Depreciation & Amortization	207,438	240,000	32,562	13.6%
8,641	10,091	1,450	14.4%	Insurance Expense	46,143	60,546	14,403	23.8%
33,891	60,845	26,954	44.3%	Repair & Maintenance	258,924	461,130	202,206	43.9%
12,402	24,446	12,044	49.3%	Other Operating Expenses	164,357	146,676	(17,681)	(12.1%)
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
120,629	**166,523**	**45,894**	**27.6%**	**Total Administrative Expenses**	**824,178**	**999,138**	**174,960**	**17.5%**
35,794	**(32,713)**	**68,507**	**209.4%**	**Change in Net Assets**	**118,449**	**(196,278)**	**314,727**	**160.3%**

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CalOptima Health
Building - 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
11,065	56,667	45,602	80.5%	Purchased Services	18,031	170,001	151,970	89.4%
9,397	-	(9,397)	(100.0%)	Depreciation & Amortization	28,192	-	(28,192)	(100.0%)
4,415	-	(4,415)	(100.0%)	Insurance Expense	13,244	-	(13,244)	(100.0%)
30,009	-	(30,009)	(100.0%)	Repair & Maintenance	69,725	-	(69,725)	(100.0%)
1,749	-	(1,749)	(100.0%)	Other Operating Expenses	4,228	-	(4,228)	(100.0%)
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
56,635	**56,667**	**32**	**0.1%**	**Total Administrative Expenses**	**133,420**	**170,001**	**36,581**	**21.5%**
(56,635)	**(56,667)**	**32**	**0.1%**	**Change in Net Assets**	**(133,420)**	**(170,001)**	**36,581**	**21.5%**

OTHER PROGRAM INCOME STATEMENTS – DECEMBER MONTH:

ONECARE CONNECT

- **CHANGE IN NET ASSETS** is $36,498, favorable to budget $36,498 due to prior year activities

PACE

- **CHANGE IN NET ASSETS** is $0.4 million, favorable to budget $0.6 million

MSSP

- **CHANGE IN NET ASSETS** is ($56,813), favorable to budget $14,713

NON-OPERATING INCOME STATEMENTS – DECEMBER MONTH

BUILDING 500

- **CHANGE IN NET ASSETS** is $35,794, favorable to budget $68,507
  - Net of $0.2 million in rental income and $0.1 million in expenses

BUILDING 7900

- **CHANGE IN NET ASSETS** is ($56,635), favorable to budget $32

INVESTMENT INCOME

- Favorable variance of $19.1 million due to $11.6 million of interest income and $7.4 million realized and unrealized net gain on investments

CalOptima Health
Balance Sheet
December 31, 2023

		December-23	November-23	$ Change	% Change
ASSETS					
Current Assets					
	Cash and Cash Equivalents	824,928,374	787,560,580	37,367,794	4.7%
	Short-term Investments	1,654,823,000	1,682,516,212	(27,693,212)	(1.6%)
	Premiums due from State of CA and CMS	460,716,756	495,606,019	(34,889,263)	(7.0%)
	Prepaid Expenses and Other	13,243,303	15,093,584	(1,850,281)	(12.3%)
	Total Current Assets	**2,953,711,433**	**2,980,776,395**	**(27,064,962)**	**(0.9%)**
Board Designated Assets					
	Cash and Cash Equivalents	1,860,785	3,568,555	(1,707,770)	(47.9%)
	Investments	627,403,051	617,954,130	9,448,921	1.5%
	Total Board Designated Assets	**629,263,837**	**621,522,686**	**7,741,151**	**1.2%**
Restricted Deposit		**300,000**	**300,000**	**-**	**0.0%**
Capital Assets, Net		**94,257,396**	**91,488,225**	**2,769,171**	**3.0%**
Total Assets		**3,677,532,665**	**3,694,087,306**	**(16,554,640)**	**(0.4%)**
Deferred Outflows of Resources					
	Advance Discretionary Payment	49,999,717	49,999,717	-	0.0%
	Net Pension	24,373,350	24,373,350	-	0.0%
	Other Postemployment Benefits	1,596,000	1,596,000	-	0.0%
	Total Deferred Outflows of Resources	**75,969,067**	**75,969,067**	**-**	**0.0%**
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		**3,753,501,732**	**3,770,056,373**	**(16,554,640)**	**(0.4%)**
LIABILITIES					
Current Liabilities					
	Medical Claims Liability	1,671,827,995	1,677,619,379	(5,791,384)	(0.3%)
	Provider Capitation and Withholds	127,263,602	138,647,911	(11,384,310)	(8.2%)
	Accrued Reinsurance Costs to Providers	4,640,925	4,348,775	292,150	6.7%
	Unearned Revenue	15,072,620	35,139,960	(20,067,340)	(57.1%)
	Accounts Payable and Other	15,311,331	13,836,194	1,475,136	10.7%
	Accrued Payroll and Employee Benefits and Other	21,550,438	21,341,659	208,779	1.0%
	Deferred Lease Obligations	36,210	39,424	(3,214)	(8.2%)
	Total Current Liabilities	**1,855,703,121**	**1,890,973,303**	**(35,270,183)**	**(1.9%)**
	GASB 96 Subscription Liabilities	17,633,828	15,655,923	1,977,906	12.6%
	Postemployment Health Care Plan	19,254,529	19,212,627	41,902	0.2%
	Net Pension Liability	40,465,145	40,465,145	-	0.0%
Total Liabilities		**1,933,056,623**	**1,966,306,999**	**(33,250,375)**	**(1.7%)**
Deferred Inflows of Resources					
	Net Pension	3,387,516	3,387,516	-	0.0%
	Other Postemployment Benefits	7,788,000	7,788,000	-	0.0%
	Total Deferred Inflows of Resources	**11,175,516**	**11,175,516**	**-**	**0.0%**
Net Position					
	Required TNE	116,147,176	112,882,602	3,264,574	2.9%
	Funds in excess of TNE	1,693,122,417	1,679,691,256	13,431,161	0.8%
	Total Net Position	**1,809,269,593**	**1,792,573,858**	**16,695,735**	**0.9%**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION		**3,753,501,732**	**3,770,056,373**	**(16,554,640)**	**(0.4%)**

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BALANCE SHEET – DECEMBER MONTH:

ASSETS of $3.8 billion decreased $16.6 million from November or 0.4%

- Premiums due from the State of California (CA) and the Centers for Medicare & Medicaid Services (CMS) decreased $34.9 million due to timing of cash receipts
- Operating Cash and Short-term Investments net increase of $9.7 million due to the receipt of the DHCS CalAIM IPP of $17.2 million, offset by risk pool payments
- Total Board Designated Assets increased $7.7 million due to continued higher returns on investments driven by changes to interest rates and economy

LIABILITIES of $1.9 billion decreased $33.3 million from November or 1.7%

- Unearned Revenue decreased $20.1 million due to recognition of previously deferred CalAIM IPP funds
- Provider Capitation and Withholds decreased $11.4 million due to Proposition 56 estimates and timing of capitation payments
- Medical Claims Liabilities decreased $5.8 million due to timing of claims payments

NET ASSETS of $1.8 billion, increased $16.7 million from November or 0.9%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of December 31, 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	257,033,006				
	Tier 1 - MetLife	254,835,681				
Board Designated Reserve		511,868,687	364,181,101	570,036,077	147,687,586	(58,167,390)
	Tier 2 - Payden & Rygel	58,871,662				
	Tier 2 - MetLife	58,523,487				
TNE Requirement		117,395,149	116,147,176	116,147,176	1,247,973	1,247,973
	Consolidated:	**629,263,836**	**480,328,277**	**686,183,253**	**148,935,559**	**(56,919,417)**
	Current reserve level	*1.83*	*1.40*	*2.00*		

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CalOptima Health
Statement of Cash Flow
December 31, 2023

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	16,695,735	139,263,340
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation & Amortization	1,260,349	6,732,968
Changes in assets and liabilities:		
Prepaid expenses and other	1,850,281	1,817,399
Capitation receivable	34,889,263	13,206,942
Medical claims liability	(5,499,234)	36,230,156
Deferred revenue	(20,067,340)	(48,370,292)
Payable to health networks	(11,384,310)	1,819,576
Accounts payable	1,475,136	229,387
Accrued payroll	250,681	(1,502,423)
Other accrued liabilities	1,974,691	1,507,014
Net cash provided by/(used in) operating activities	21,445,253	150,934,068
GASB 68, GASB 75 and Advance Discretionary Payment Adjustments	-	(49,999,717)
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	27,693,212	21,913,064
Change in Property and Equipment	(4,029,520)	(16,782,859)
Change in Restricted Deposit & Other	-	-
Change in Board designated reserves	(7,741,151)	(52,712,143)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	15,922,541	(47,581,938)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	37,367,794	53,352,413
CASH AND CASH EQUIVALENTS, beginning of period	$787,560,580	771,575,961
CASH AND CASH EQUIVALENTS, end of period	**824,928,374**	**824,928,374**

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CalOptima Health - Consolidated
Net Assets Analysis
For the Six Months Ending December 31, 2023

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 12/31/2023	**$1,809.3**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**629.3**			**34.8%**
	Capital Assets, net of Depreciation[2]	**94.3**			**5.2%**
Resources Allocated[3]	Homeless Health Initiative[4]	$18.4	$59.9	$41.5	1.0%
	Housing and Homelessness Incentive Program[4]	54.1	122.2	68.1	3.0%
	Intergovernmental Transfers (IGT)	58.3	111.7	53.4	3.2%
	Digital Transformation and Workplace Modernization	62.2	100.0	37.8	3.4%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	Outreach Strategy for CalFresh, Redetermination support, and other programs	5.8	8.0	2.2	0.3%
	Coalition of Orange County Community Health Centers Grant	30.0	50.0	20.0	1.7%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	0.6	1.0	0.4	0.0%
	General Awareness Campaign	1.3	2.7	1.4	0.1%
	Member Health Needs Assessment	0.7	1.0	0.3	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	145.1	153.5	8.4	8.0%
	Medi-Cal Annual Wellness Initiative	2.0	3.8	1.8	0.1%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.6%
	In-Home Care Pilot Program with the UCI Family Health Center	1.5	2.0	0.5	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	4.0	5.0	1.0	0.2%
	Community Living and PACE center (previously approved for project located in Tustin)	17.6	18.0	0.4	1.0%
	Stipend Program for Master of Social Work Students	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program	2.1	2.7	0.6	0.1%
	CalOptima Health Provider Workforce Development Fund	50.0	50.0	0.0	2.8%
	Distribution Event- Naloxone	2.5	15.0	12.5	0.1%
	Garden Grove Bldg Improvement	10.4	10.5	0.1	0.6%
	Post-Pandemic Supplemental	66.4	107.5	41.1	3.7%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	2.1%
	Outreach Strategy for newly eligible Adult Expansion members	2.5	2.5	0.0	0.1%
	Quality Initiatives from unearned Pay for Value Program	23.3	23.3	0.0	1.3%
	Subtotal:	**$606.9**	**$919.3**	**$312.5**	**33.5%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$478.9**			**26.5%**

[1] Total of Board Designated Reserve and unallocated reserve amount can support approximately 95 days of CalOptima Health's current operations
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements
[3] Initiatives that have been paid in full in the previous year are omitted from the list of Resources Allocated
[4] See HHI and HHIP summaries and Allocated Funds for list of Board approved initiatives

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CalOptima Health
Key Financial Indicators
As of December 31, 2023

	Item Name	December 2023					July - December 2023				
		Actual	Budget	Variance	%		Actual	Budget	Variance	%	
Income Statement	*Member Months*	954,214	911,024	43,190	4.7%		5,836,920	5,709,332	127,588	2.2%	
	Operating Revenue	388,535,659	334,244,580	54,291,079	16.2%		2,368,868,998	2,088,838,607	280,030,391	13.4%	
	Medical Expenses	374,249,429	318,567,307	(55,682,122)	(17.5%)		2,183,823,010	1,954,368,555	(229,454,455)	(11.7%)	
	General and Administrative Expense	18,203,266	20,737,242	2,533,976	12.2%		109,061,671	124,195,589	15,133,918	12.2%	
	Non-Operating Income/(Loss)	20,612,772	990,731	19,622,041	1,980.6%		63,279,022	(13,885,615)	77,164,637	555.7%	
	Summary of Income & Expenses	16,695,735	(4,069,238)	20,764,974	510.3%		139,263,340	(3,611,152)	142,874,492	3,956.5%	
Ratios	**Medical Loss Ratio (MLR)**	**Actual**	**Budget**	**Variance**			**Actual**	**Budget**	**Variance**		
	Consolidated	96.3%	95.3%	1.0%			92.2%	93.6%	(1.4%)		
	Administrative Loss Ratio (ALR)	**Actual**	**Budget**	**Variance**			**Actual**	**Budget**	**Variance**		
	Consolidated	4.7%	6.2%	1.5%			4.6%	5.9%	1.3%		

Key:

> 0%	
> -20%, < 0%	
< -20%	

Investment	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
	@12/31/2023	2,264,534,627	2,284,791,597	(20,256,970)	(0.9%)

Unallocated/Unassigned Reserve Balance	Current Month @ December 2023	Fiscal Year Ending June 2022	Change	%
Consolidated	478,863,810	354,771,258	124,092,552	35.0%
*Days Cash On Hand**	95			

*Total of Board Designated reserve and unallocated reserve amount can support approximatley 95 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 Six Months Ending December 31, 2023

	December 2023				July - December 2023				All Time to Date			
	Actual Spend	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**
Capital Assets (Cost, Information Only):												
Total Capital Assets	**111,646**	**1,836,414**	**1,724,768**	**93.9%**	**17,649,892**	**10,668,484**	**(6,981,408)**	**(65.4%)**	**21,247,943**	**47,514,484**	**26,266,541**	**55.3%**
Operating Expenses:												
Salaries, Wages & Benefits	633,886	609,649	(24,237)	(4.0%)	3,708,939	3,657,894	(51,045)	(1.4%)	7,127,515	8,950,127	1,822,612	20.4%
Professional Fees	54,167	192,916	138,749	71.9%	375,899	1,087,496	711,597	65.4%	642,092	3,319,996	2,677,904	80.7%
Purchased Services	16,667	155,000	138,333	89.2%	216,667	930,000	713,333	76.7%	216,667	1,240,000	1,023,333	82.5%
Other Expenses	727,138	1,371,009	643,871	47.0%	5,582,039	7,856,054	2,274,015	28.9%	8,596,815	11,148,434	2,551,619	22.9%
Total Operating Expenses	**1,431,858**	**2,328,574**	**896,717**	**38.5%**	**9,883,544**	**13,531,444**	**3,647,900**	**27.0%**	**16,583,090**	**24,658,557**	**8,075,467**	**32.7%**

Funding Balance Tracking:	**Actual Spend**	**Approved Budget**
Beginning Funding Balance	100,000,000	100,000,000
Less:		
FY2023	10,297,597	47,973,113
FY2024	27,533,436	49,189,899
FY2025		
Ending Funding Balance	**62,168,967**	**2,836,988**

Note: Report includes applicable transactions for GASB 96, Subscription.

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CalOptima Health

Summary of Homeless Health Initiatives (HHI) and Allocated Funds

As of December 31, 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 & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	727,506	235,755
FQHC (Community Health Center) Expansion	21,902	21,902	-
HCAP and CalOptima Health Days	9,888,914	3,170,400	6,718,514
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine	8,276,652	3,907,116	4,369,536
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[1]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$ 100,000,000**	**$ 41,463,974**	**$ 58,536,026**
Transfer of funds to HHIP[1]	(40,100,000)	-	(40,100,000)
Program Total	**$ 59,900,000**	**$ 41,463,974**	**$ 18,436,026**

Notes:

[1]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP.

CalOptima Health

Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds

As of December 31, 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	382,200	417,800
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	2,922,299	1,099,013
Infrastructure Projects	5,832,314	5,288,398	543,916
Capital Projects	98,247,369	57,300,000	40,947,369
System Change Projects	10,180,000	-	10,180,000
Non-Profit Healthcare Academy	354,530	56,013	298,517
Total of Approved Initiatives	**$ 122,235,524** [1]	**$ 68,148,910**	**$ 54,086,615**

Notes:

[1]Total funding $122.2M: $40.1M Board-approved reallocation from HHI, $47.2M from CalOptima Health existing reserves and $34.8M from DHCS HHIP incentive payments

CalOptima Health
Budget Allocation Changes
Reporting Changes as of December 2023

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	Purchased Services - TB Shots, Flu Shots, COVID Related Services & COVID Cleaning/Building Sanitization	Moving Services	$40,000	To repurpose from TB/Flu Shots and COVID Cleaning to provide more funding for Moving Services. ($16,000 from TB Shots, Flu Shots, COVID related services, $24,000 from COVID Cleaning/Building Sanitization)	2023-24
July	Medi-Cal	DTS Capital: I&O Internet Bandwidth	DTS Capital: I&O Network Bandwidth	$36,000	To reallocate funds from I&O Internet Bandwidth to I&O Network Bandwidth to cover shortage of fund for RFP.	2023-24
July	OneCare	Communication - Professional Fees Marketing/Advertising Agency Consulting	Community Relations - Membership Fees	$60,000	To reallocate funds from Communication – Professional Fees Marketing/Advertising Agency Consulting to Community Relations – Membership Fees to help fund E-Indicator Sponsorship bi-weekly newsletter.	2023-24
July	Medi-Cal	Corporate Application HR - Dayforce In-View	Corporate Application HR - SilkRoad OpenHire and Wingspan	$23,000	To reallocate funds from Corporate Application HR - Dayforce Inview to Corporate Application HR-SilkRoad OpenHire and Wingspan due to short of funds for renewal of contract.	2023-24
August	Medi-Cal	Quality Analytics – Other Operating Expenses - Incentives	Case Management – Other Operating Expenses - WPATH – Health Plan Provider Training	$24,500	To reallocate funding from Quality Analytics – Incentives to Case Management – WPATH – Health Plan Provider Training to provide funding for Blue Peak training.	2023-24
August	Medi-Cal	Quality Analytics - Other Operating Expenses - Incentives	Utilization Management – Purchased Services	$74,000	To reallocate funds from Quality Analytics – Incentives(MC) and Pharmacy Management – Professional Fees (OC) to Utilization Management – Purchased Services to provide funding for the Periscope Implementation.	2023-24
August	One Care	Pharmacy Management – Professional Fees	Utilization Management – Purchased Services	$15,000	To reallocate funds from Quality Analytics – Incentives(MC) and Pharmacy Management – Professional Fees (OC) to Utilization Management – Purchased Services to provide funding for the Periscope Implementation.	2023-24
August	Medi-Cal	Strategic Development - Professional Fees - DC Equity Consultant & Equity Initiative Activities	Strategic Development - Other Operating Expenses - Incentives	$67,000	To reallocate funds from Professional Fees – Equity Consultant, and Equity Initiative Activities to Purchased Services – Gift Cards to provide funding to purchase member incentive gift cards.	2023-24
September	One Care	Office of Compliance - Professional Fees - CPE Audit	Office of Compliance - Professional Fees - Blue Peak Services	$20,000	To reallocate funds from Professional Fees – CPE Audit to Professional Fees – Blue Peak Services to provide funding for Blue Peak Services.	2023-24
September	Medi-Cal	Customer Service - Member Communication – Maintenance of Business, Ad-Hoc/New Projects	Provider Data Mgmt Svcs – Purchased Services	$60,000	To reallocate funds from Customer Service – Member Communication Maintenance of Business and Ad-Hoc/New Projects to Provider Data Management Services – Purchased Services to provide funding for provider directory PDF Remediation services.	2023-24
September	Medi-Cal	Facilities - Audio Visual Enhancements	Facilities - CalOptima Health New Vehicle	$13,135	To reallocate funds from Facilities – Audio Visual Enhancements to Facilities – CalOptima Health New Vehicle for a new company vehicle.	2023-24
September	Medi-Cal	Medical Management – Other Operating Expenses – Training & Seminar	Behavioral Health Integration – Professional Fees	$16,000	To reallocate funds from Medical Management – Other Operating Expenses – Training & Seminar to Behavioral Health Integration – Professional Fees to provide funding for Autism Spectrum Therapies.	2023-24
September	Medi-Cal	Population Health Management – Purchased Services – Capacity Building Vendor	Population Health Management – Purchased Services – Capacity Building	$150,000	To repurpose funds from Purchased Services – Capacity Building Vendor to support the new Medi-Cal benefit, including incentives for contracting with CCN and delegated Health Networks, doula training, and technical assistance.	2023-24
September	Medi-Cal	IS – Enterprise Data & Sys Integration – Professional Fees	Enterprise Project Management Office – Professional Fees	$75,000	To reallocate funds from Enterprise Project Management Office – Training & Seminar, IS – Enterprise Data & Sys Integration – Professional Fees and IS – Application Development – Maintenance HW/SW to provide funding for the BCP consultation project.	2023-24
September	Medi-Cal	IS – Application Development – Maintenance HW/SW	Enterprise Project Management Office – Professional Fees	$55,000	To reallocate funds from Enterprise Project Management Office – Training & Seminar, IS – Enterprise Data & Sys Integration – Professional Fees and IS – Application Development – Maintenance HW/SW to provide funding for the BCP consultation project.	2023-24
October	Medi-Cal	DTS Capital: Migrate Data Warehouse / Analytics to the Cloud	DTS Capital: Enterprise Data Quality Enhancement	$140,000	To reallocate funds from AppDev – Migrate Data Warehouse Analytics to AppDev – Enterprise Data Quality Enhancement to help with Collibra Data Governance invoice.	2023-24
October	Medi-Cal	Medi-Cal/Claim - Other Operating Expenses - Food Service Supply	Medi-Cal/Claim - Other Operating Expenses - Travel	$16,000	To reallocate funds from Medi-Cal/Claim – Food Service Supply to Medi-Cal/Claim – Travel to provide funding for Center for Care Innovations.	2023-24
October	Medi-Cal	Is – Infrastructure – Other Operating Expenses – Maintenance HW/SW	Provider Data Management Services – Purchased Services	$54,000	To reallocate funds from IS – Infrastructure – Microsoft Enterprise License Agreement, Sales & Marketing – FMO OneCare Marketing Partnership and IS – Application Management – Enthrive to Provider Data Management Services to provide funding for the provider directory PDF remediation service.	2023-24
October	One Care	IS – Application Management – Maintenance HW/SW	Provider Data Management Services - Purchased Services	$24,000	To reallocate funds from IS – Infrastructure – Microsoft Enterprise License Agreement, Sales & Marketing – FMO OneCare Marketing Partnership and IS – Application Management – Enthrive to Provider Data Management Services to provide funding for the provider directory PDF remediation service.	2023-24
November	Medi-Cal	IS - Application Management - Maintenance HW/SW	Medical Management - Professional Fees	$100,000	To reallocate funds from IS-Applications Management - Maintenance HW/SW IBM WebSphere to Medical Management - Professional Fees to fund a consulting project.	2023-24
November	Medi-Cal	Executive Office - Professional Fees	Executive Office - Other Operating Expenses - Professional Dues	$28,000	To reallocate funds from Professional Fees to Professional Dues to pay for CCI Membership.	2023-24
November	Medi-Cal	Infrastructure - Misc. HW/SW Technology Equipment (New Hire Equip)	Infrastructure - HW/SW Maintenance (Palo Alto Firewall)	$84,000	To reallocate funds from Infrastructure Misc. HW/SW Technology Equipment (New Hire Equipment) to HW/SW Maintenance (Palo Alto Firewall) to help with shortage of funds due to contract is co-termed.	2023-24
December	Medi-Cal	505 Building - Repair & Maintenance	505 Building - Purchased Services	$228,798	To reallocate funds from Repair & Maintenance to Purchased Services to move security contracts to the appropriate account.	2023-24
December	Medi-Cal	500 Building - Repair & Maintenance	500 Building - Purchased Services	$192,120	To reallocate funds from Repair & Maintenance to Purchased Services to move security contracts to the appropriate account.	2023-24
December	Medi-Cal	Infrastructure - Misc HW/SW Equip Sup	Infrastructure - Maintenance HW/SW - F5 Network	$47,000	To reallocate funds from Infrastructure - Misc HW/SW Equip Supplies to Infrastructure - Maintenance HW/SW - F5 Network and Infrastructure - Maintenance HW/SW - Calabrio to help with the annual renewal invoice. renewal invoice.	2023-24
December	Medi-Cal	Infrastructure - Misc HW/SW Equip Sup	Infrastructure - Maintenance HW/SW - Calabrio	$29,000	To reallocate funds from Infrastructure - Misc HW/SW Equip Supplies to Infrastructure - Maintenance HW/SW - F5 Network and Infrastructure - Maintenance HW/SW - Calabrio to help with the annual renewal invoice. renewal invoice.	2023-24
December	Medi-Cal	Application Mgmt - Maintenance HW/SW (IBM WebSphere)	Enterprise Data & Sys Integration - Maintenance HW/SW (Tableau)	$249,990	To reallocate funds from Application Mgmt - Maintenance HW/SW (IBM WebSphere) to Enterprise Data & Sys Integration - Maintenance HW/SW (Tableau) to help with Tableau invoice.	2023-24
December	Medi-Cal	Facilities - Comp supply/Minor Equipment	Facilities - R&M - Building	$100,000	To reallocate fund from Comp Supply/Minor Equipment to R&M - Building to address unanticipated repair costs.	2023-24
December	Medi-Cal	Professional Fees - Altruista	Purchased Services - MCG	$40,000	To reallocate funds from Professional Fees - Altruista to Purchased Services - MCG to help with CMS requirement to add a link in CalOptima Health's website for Medicare members.	2023-24

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
February 1, 2024

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima Health's Board of Directors including, but not limited to, updates on internal and health network monitoring and audits conducted by CalOptima Health's Delegation Oversight and Internal Audit departments, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. Medicare

- **2023 Compliance Program Effectiveness (CPE) Audit *(applicable to OneCare)*:**

***Update*:**

- CalOptima Health contracted with an independent consulting firm to conduct a CPE audit of CalOptima Health.
- The final CPE Audit Report was issued on November 27, 2023.
- Work is underway to address the audit observations and recommendations as appropriate.

The audit results consisted of two observations as follows:

- **Observation #1: Corrective Actions**:
  - The Plan undertakes timely and reasonable corrective action in response to compliance issues, incidents, investigations, complaints, or misconduct involving non-compliance and potential FWA issues. However, there were some opportunities for enhancements to ensure effective corrective actions.

- **Observation #2-- Conducting Timely and Reasonable Inquiry of Detected Offenses:**
  - It was noted during the review of the FWA tracer summary (Tracer #1) that the outreach to the twelve (12) potentially impacted enrollees did not follow the process of three (3) outreach attempts. Only 1 outreach attempt was made to 11 of the 12 potentially impacted enrollees.

***Background*:**

- CalOptima Health is required to conduct an independent audit on the effectiveness of its Compliance program on an annual basis. The audit review period was from February 1, 2023, through August 1, 2023.

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- **CY2022 Centers for Medicare & Medicaid Services (CMS) Financial Audit *(applicable to OneCare)*:**

  Update:
  - CMS notified CalOptima Health that its OneCare plan has been selected for the CY2022 CMS Financial Audit and Davis Farr LLP will conduct the audit. Davis Farr LLP will act in the capacity of CMS agents and request records and supporting documentation for, but not limited to, the following items:
    - Claims data
    - Solvency
    - Enrollment
    - Base year entries on the bids
    - Medical and/or drug expenses
    - Related party transactions
    - General administrative expenses
    - Direct and Indirect Remuneration (DIR)
  - On November 9, 2023, CalOptima Health received the Initial Document Request from Davis Farr LLP and submitted the subsampling requests on December 8, 2023, and the remaining documents on December 15, 2023.
  - CalOptima Health received the first round of Part D Sample Requests and is currently pending Part C Sample Requests from the auditor.
  - The Entrance Conference with both the auditor and CMS is scheduled for January 22, 2024.

  Background:
  - At least one-third of Medicare Advantage Organizations (MAOs) are selected for the annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CMS will audit and inspect any books and records of the MAO that pertain to 1) the ability of the organization to bear the risk of potential financial losses, or 2) services performed or determinations of amounts payable under the contract. The Pharmacy Benefit Management (PBM) company will also be required to provide CMS with all requested supporting documentation for this audit.

- **2024 Medicare Part C and Part D Data Validation Audit (MDVA) (*applicable to OneCare*):**

  Update:
  - CalOptima Health has contracted with an independent consulting firm to conduct its annual MDVA audit as required by Medicare Advantage and Part D (MAPD) regulations.
  - The consulting firm has started training sessions to prepare the plan for the upcoming 2024 MDVA audit season.
  - In preparation for the audit to commence in 2024, Regulatory Affairs and Compliance (RAC) requested the collection of the universes. The reporting measures will be submitted no later than the regulatory deadlines of February 5 and February 26, 2024.

- **2024 Centers for Medicare & Medicaid Services (CMS) Readiness Checklist (*applicable to OneCare*):**

  ***Update*:**
  - On October 13, 2023, CMS released the 2024 CMS Readiness Checklist. CalOptima Health is expected to fulfill key operational requirements summarized in the readiness checklist for the 2024 benefit year.
  - A kickoff email was sent on October 27, 2023, to the respective operational areas to begin the validation process.
  - The validation audit activities are expected to conclude by early January 2024.

  ***Background*:**
  - The 2024 Readiness Checklist is a tool for organizations to use in preparation for the upcoming year. It does not supersede requirements as established in statutes or regulations as they relate to Medicare Advantage Organizations (MAOs), Prescription Drug Plans (PDPs), 1876 Cost Plans. CMS recommends that organizations review this checklist and take the necessary steps to fulfill requirements for CY 2024.

- **CY 2024 Monitoring of Posted Comprehensive Formularies *(applicable to OneCare)*:**

  Update:
  - On November 28, 2023, CMS identified potential discrepancies between the posted and CMS approved HPMS (Health Plan Management System) formularies. CMS requested CalOptima Health to submit a completed response form by December 5, 2023.
  - On December 1, 2023, Pharmacy submitted the response form via the Acumen Formulary Web Portal.
    - The responses are expected to clarify the alignment of the posted and CMS approved formularies effectively closing out the inquiry.

  Background:
  - To ensure the accuracy of required formulary communication materials, CMS conducts a review comparing the CY 2024 formularies posted on plan websites to those within HPMS that will be effective January 1, 2024. CMS will select a random sample of Part D plans for inclusion in the analysis.

- **2024 CMS Program/Focused Audit Readiness *(applicable to OneCare)*:**

  Update:
  - In anticipation of the CMS focused audit, a kick-off meeting to review the current CMS audit protocols and the internal audit workplan is scheduled for February 29, 2024.

  Background:
  - On October 24, 2023, CMS announced it is adding a new focused audit for Plans who do not have 2024 routine scheduled program audits, which are limited to ODAG (Organization Determinations Appeals and Grievances) and CPE. This new focused audit is designed to specifically target compliance with the coverage and UM policies finalized in CMS-4201-F, which is effective January 1, 2024.

- **CY 2021 OIG Nationwide Acute Stroke Audit *(applicable to OneCare Connect)*:**

  Update:
  - CalOptima Health received the audit notification letter on November 30, 2023, and submitted the requested documentation on December 12, 2023.
  - The documentation provided does not support the acute stroke diagnosis code submitted by CalOptima Health.

  Background:
  - The U.S. Department of Health and Human Services, Office of Inspector General (OIG) is conducting a nationwide audit of risk adjustment payments that CMS made to MA organizations for calendar year 2021. Specifically, OIG has selected to review a sample of an enrollee for which CalOptima Health submitted an acute stroke diagnosis code to CMS under the OneCare Connect contract (H8016). This is an audit of CMS and is not an audit of CalOptima Health.

2. Medi-Cal

- **2024 Managed Care Plan (MCP) Operational Readiness Contract:**

  Update:
  - As of December 29, 2023, CalOptima Health has submitted **230** deliverables for 2024 MCP operational readiness.
  - **217 items have received approval** at this point.
  - **13 items are pending** DHCS (Department of Health Care Services) review and approval.
    - This submission concludes operational readiness deliverables. Once the 13 deliverables are reviewed and approved by DHCS; no additional deliverables will be required.

  Background – FYI Only
  Throughout CY 2022 and CY 2023, MCPs, including CalOptima Health are 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 Department of Health Care Services (DHCS) Routine Medical Audit:**

  Final Update:
  - On December 29, 2023, DHCS notified CalOptima Health that its corrective action plan for the 2023 DHCS Medical Audit was accepted and closed. No further action is required.

  - As with all DHCS annual/routine audits, and in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final audit report and final CAP remediation document will be made available on the DHCS website and to the public upon request.

B. Regulatory Notices of Non-Compliance

- CalOptima Health did not receive any notices of non-compliance from its regulators for the months of November and December 2023.

C. Updates on Health Network Monitoring and Audits

- **Health Network Audits:**

  - CalOptima Health's Delegation Oversight (DO) department completed annual audits on the following delegated health networks to assess their capabilities and performance with delegated activities:
    - AltaMed Health Services Corp., July 1, 2022 – June 30, 2023
    - Optum Care Network – Arta, July 1, 2022 – June 30, 2023
    - Optum Care Network – Monarch, July 1, 2022 – June 30, 2023
    - Optum Care Network – Talbert, July 1, 2022 – June 30, 2023
  - Audit tools and elements were derived from accrediting, regulatory and CalOptima Health contractual standards. For areas that scored below the 100% threshold, DO 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.
  - CalOptima Health will validate the effectiveness of corrective actions once implementation is complete.

D. Internal Audit Updates

- **Internal Annual Audit:**

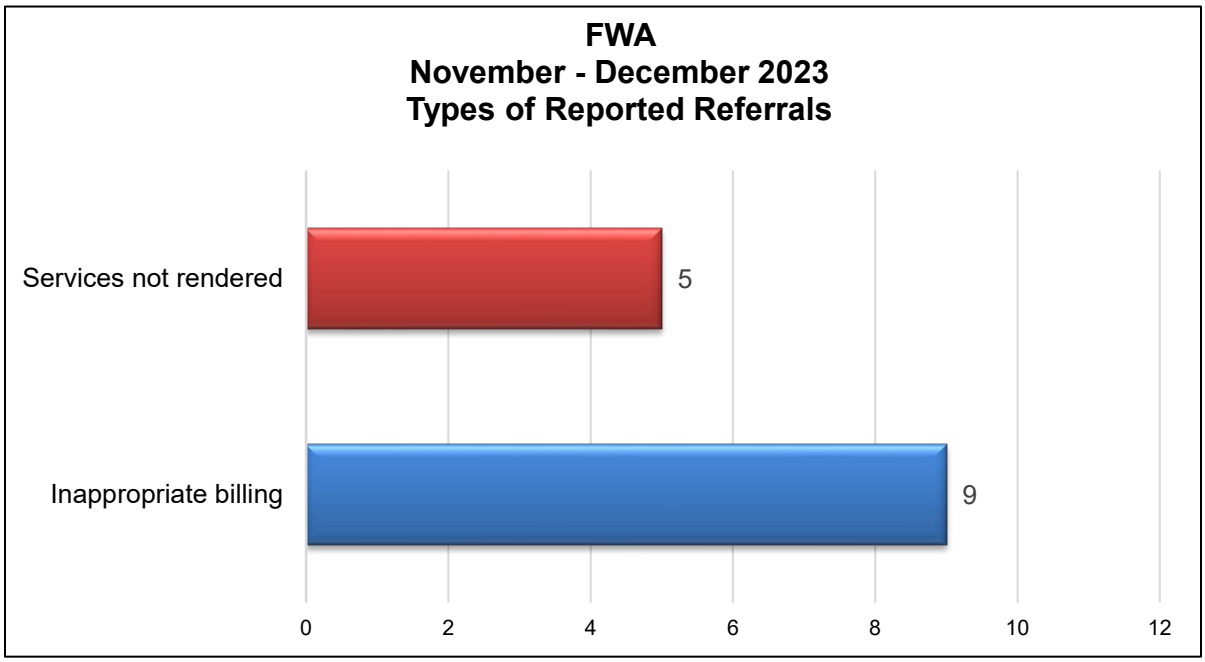
  - CalOptima Health's Internal Audit department is currently engaged in three (3) internal audits to assess regulatory compliance with universe, timeliness, clinical decision-making, and processing requirements.
  - The following audits (Line of Business) are currently in progress:
    - Utilization Management (Medi-Cal)
      - Lookback Period: January 1, 2023, to May 31, 2023
      - Status: CAPs issued and in-process of remediation
    - Utilization Management (OneCare)
      - Lookback Period: January 1, 2023, to June 30, 2023
      - Status: CAPs issued and in-process of remediation
    - Grievance and Appeals (Medi-Cal)
      - Lookback Period: January 1, 2023, to July 31, 2023
      - Status: Audit in progress (current stage: file review)
    - CDAG Pharmacy and GARS Grievance Part D Annual Audit
      - Lookback Period: January 1, 2023, to November 30, 2023
      - Status: Audit in progress (current stage: file review)

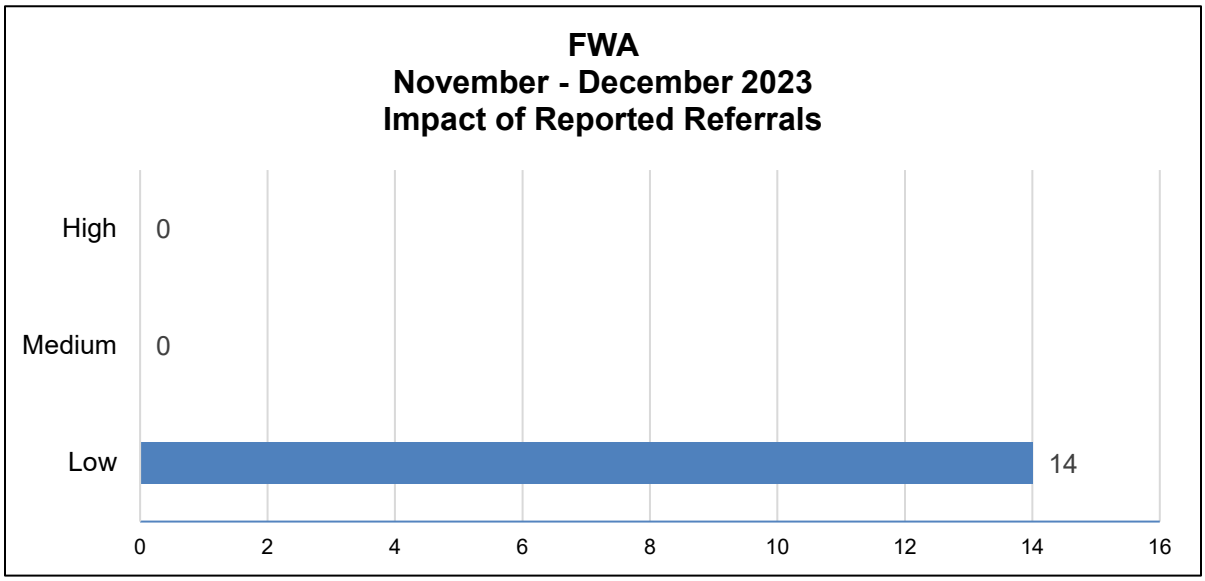
- The following audits (Line of Business) have been completed:
  - PACE
    - Lookback Period: May 28, 2022, to November 28, 2022
    - Status: CAPs remediated and closed; present to Compliance Committee on January 25, 2024
  - Customer Service (Medi-Cal)
    - Lookback Period: January 1, 2023, to April 30, 2023
    - Status: CAPs remediated and closed; present to Compliance Committee on January 25, 2024
  - Grievances and Appeals (OneCare)
    - Lookback Period: January 1, 2023, to April 30, 2023
    - Status: CAPs remediated and closed; present to Compliance Committee on January 25, 2024

- **Board-Approved Initiatives Review:**

  - CalOptima's Internal Audit department is currently in process of reviewing CalOptima's Board-approved initiatives. Internal Audit's goal is to strengthen the oversight of the fund's surplus expenditure management process, including the structure for reviewing and signing off on grant programs and initiatives.
  - There are 25 Board-approved initiatives with total funding allocations of approximately $830 million. Initiatives are classified into the following program types:
    - Grant programs
    - Quality/Population Health Management programs
    - Strategic Initiatives

E. Fraud, Waste & Abuse (FWA) Investigations (November and December 2023)

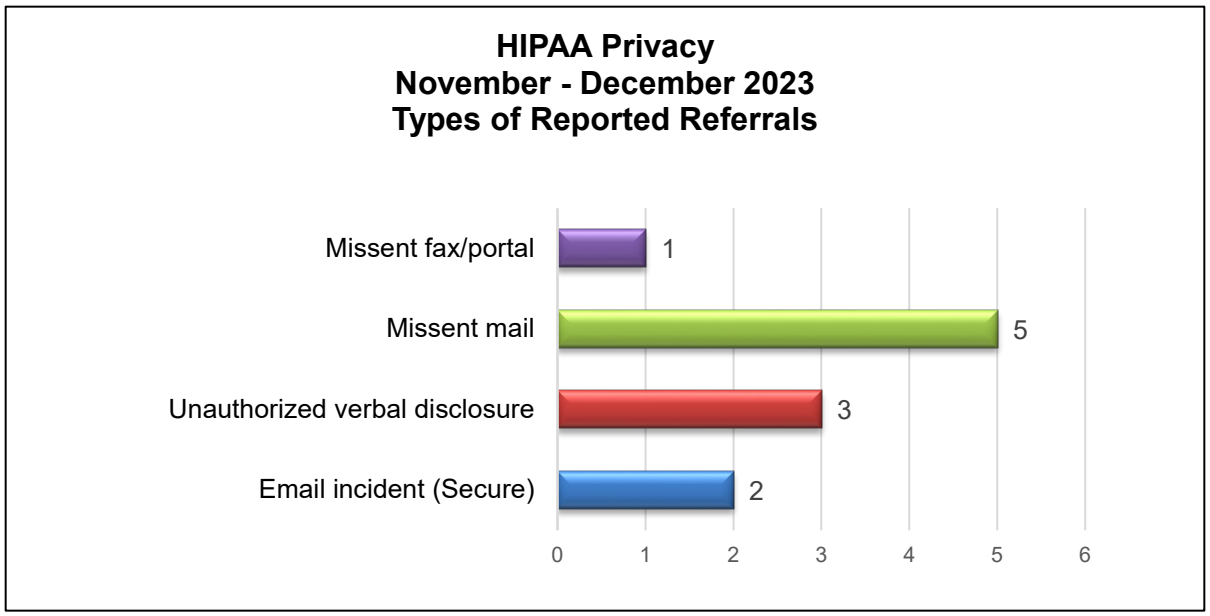


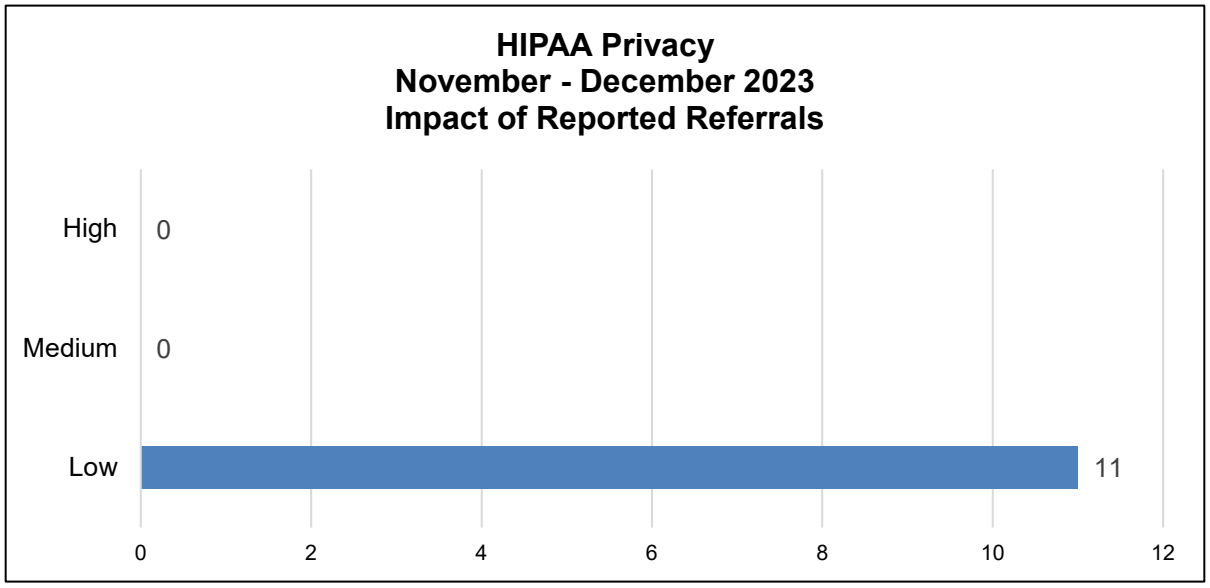


Total Number of New Cases Referred to DHCS (State)	14
Total Number of New Cases Referred to DHCS and CMS*	1
Total Number of Referrals (Subjects) Reported to Regulatory Agencies	**14**

* Any potential FWA *with impact to Medicare* is reported to CMS within 30 days of the start of an investigation.

F. Privacy Update (November and December 2023)





Total Number of Referrals Reported to DHCS (State)	11
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

POTOMAC PARTNERS DC

STRATEGIC HEALTH CARE

MEMORANDUM

January 12, 2024

To: CalOptima Health

From: Potomac Partners DC & Strategic Health Care

Re: January Board of Directors Report

FISCAL YEAR 2024 APPROPRIATIONS

Over the weekend, House Speaker Johnson (R-LA) and Senate Majority Leader Schumer (D-NY) released an agreement on the topline spending for Fiscal Year 2024 (FY24). The announcement sets topline spending at $1.659 trillion. As a reminder, the current Continuing Resolution (CR) funding the government will expire in two groups:

- **January 19, 2024**: Agriculture; Military Construction & Veterans Affairs; Energy & Water; and Transportation, Housing & Urban Development (T-HUD).

- **February 2, 2024**: Commerce-Justice-Science; Defense; Financial Services; Homeland Security; Interior-Environment; Labor-HHS-Education; Legislative Branch; and State & Foreign Operations.

Despite the announcement that a topline spending agreement has been reached, there are significant headwinds in the House where Freedom Caucus Republicans are opposed to any new spending that does not also include significant funding to close the southern border. This week, House Speaker Johnson has been in near-constant talks with the Republican caucus on a path forward, but it's looking more and more likely that another Continuing Resolution may be necessary unless a compromise is reached with House Democrats, a scenario that would jeopardize Speaker Johnson's role as Speaker. As of this report, Speaker Johnson is engaging with the House Freedom Caucus to discuss the spending levels.

SENATE HEALTH COMMITTEE LEGISLATION

The Senate Health Committee voted to approve bills aimed at increasing treatment and prevention of substance abuse. This includes the SUPPORT for Patients and Communities Reauthorization Act (S. 3393), which would renew through 2028 portions of the 2018 bipartisan SUPPORT Act

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that lapsed on October 1st that focuses on prevention, treatment, and recovery services for opioid misuse, including fentanyl. Additionally, the Committee voted on the Modernizing Opioid Treatment Access Act (S. 644), which would allow certain licensed and registered providers to prescribe methadone for opioid use disorder and for pharmacies to dispense it. The complete list of bills and video footage of the meeting is available here.

CMS Rule on Medicaid Redetermination Reporting Requirements

In an Interim Final Rule, CMS outlined how the agency will force states to submit correction plans if they fail to meet reporting requirements regarding Medicaid redeterminations, do not follow recommended timelines for dropping people, or erroneously remove people from the rolls. States found out of compliance with CMS requirements will see a 0.25 percentage point drop in federal matching funds each quarter they fail to report. Those who fail to submit or implement a corrective action plan would also be forced to suspend all terminations of Medicaid beneficiaries and receive fines of up to $100,000 per day. The full text of the rule is available here.

ACA Marketplace Data

According to the latest update from HHS, nearly 7.3 million individuals have selected ACA Health Insurance Marketplace plans since the commencement of the 2024 Marketplace Open Enrollment Period on November 1. Of the total enrollments, over 1.6 million (23 percent) are new participants, while 5.7 million (77 percent) are individuals with active 2023 coverage who returned to renew or choose new plans for 2024. The open enrollment period runs until January 15, 2024, and savings are expected for 9 out of 10 customers due to provisions in the Inflation Reduction Act. A CMS press release with more information is available here.

Trusted Exchange Framework and Common Agreement

HHS has announced the full operational functionality of a nationwide health data exchange governed by the Trusted Exchange Framework and Common Agreement (TEFCA). The following organizations were officially designated Qualified Health Information Networks (QHINs) after completing a TEFCA onboarding process: eHealth Exchange, Epic Nexus, Health Gorilla, KONZA, and MedAllies. These designated QHINs can immediately begin supporting data exchanges, including providing shared services and governance to securely route queries, responses, and messages across networks for eligible participants, including patients, providers, hospitals, health systems, payers, and public health agencies.

HHS Rule on Health IT

This week, HHS posted a final rule aimed at improving "Health IT Interoperability and Algorithm Transparency." The rule makes updates to the INC Health IT Certification Program and establishes transparency requirements for artificial intelligence (AI) and predictive algorithms, adopts the United States Core Data for Interoperability (USCDI) Version 3 (v3) as the new baseline standard, makes changes to certain information blocking definitions and exceptions, and implements 21st Century Cures Act requirements to adopt the "Insights Condition." More information on the rule is available here.

Medicare Advantage

Under new marketing guidelines for Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans, Prescription Drug Plans, and 1876 Cost Plans designed to remove deceptive advertisements, roughly one-third of television ads for plans over the past seven months were rejected. CMS said that roughly 1,000 of the 3,000 ads submitted to the agency could mislead older Americans about benefits and costs. The guidelines are available here. More and more seniors are choosing Medicare Advantage over traditional Medicare leading to more than half of beneficiaries going with the privately run program. This is not the only way that insurers are building their programs; they are also growing their MA portfolios through strategic acquisitions, with UnitedHealth and CVS Health leading the way.

CMS Innovation Center Cost More than It Saved

The Congressional Budget Office released a report that shows demonstration models created under the CMS Innovation Center cost the government $5.4 billion more than they saved. The demos were a key part of the ACA that were intended to lead to a more value-based health care system in the U.S. The full CBO report is available here.

CALOPTIMA HEALTH - STATE LEGISLATIVE REPORT
January 22, 2024

General Update

On January 3, 2024, the legislature reconvened for the second year of their two-year session. Legislators advanced their work on remaining 2023 bills (two-year bills) to meet the committee hearing deadline of January 19, as well as started working on new bills to meet the new bill introduction deadline of February 16. The next critical bill deadline is January 31 when all two-year bills must be passed out of their house of origin.

Both houses of the legislature have been relatively quiet thus far. Senator Mike McGuire will be sworn in as Senate President Pro Tem on February 5 to replace Toni Atkins. Atkins terms out of office this year and announced on January 19 that she will put her hat in the ring for Governor in 2026. Once McGuire takes the reigns, Senate leadership and committee chairs may change. However, a total upheaval is not expected.

Legislation Update

AB 1230 (Valencia) was dropped by the author at the request of LHPC and CalOptima Health and, as a result, missed the committee hearing deadline on January 19. AB 1230 would have required DHCS to offer contracts to health plans for HIDE-SNPs and FIDE-SNPs to provide care to dual-eligible beneficiaries. This would have circumvented the goals of the CalAIM initiative to streamline services for older adults.

Budget Update

The State's 2024-25 budget was presented by Governor Newsom on January 10. The biggest focus was the $37.86 billion shortfall in the Governor's budget versus the $68 billion shortfall projected by the Legislative Analyst's Office (LAO). The Governor's optimistic projections were explained as a budget "normalization" after a couple of years of higher-than-normal revenues. His proposal closes the shortfall by using reserves, delaying spending, borrowing from special funds, cutting programs (climate, housing, and education), and deferring UC and Cal State funding. The "rainy day fund" has not yet been activated, since a state of emergency will need to be declared. That fund may be tapped closer to the final budget deadline on June 15.

Health and Human Services Budget

Generally, the HHS portion of the budget remains mostly intact and continues several identified priorities of the Newsom administration. These include expanding Medi-Cal eligibility regardless of immigration status; the Behavioral Health Continuum to transform the system of delivery for children and youth; the BH-CONNECT demonstration project; and CalAIM, including allowing up to six months of rent or temporary housing to those experiencing or at risk of homelessness transitioning out of care settings. The projection for the Medi-Cal caseload is expected to decline to 13.8 million statewide because of the effects of redetermination eligibility. This number should be more certain for the May Revision of the budget since it is currently unreliable.

Managed Care Organization (MCO) Tax

As part of the proposed budget fix, the Administration will be asking for early legislation to authorize DHCS to request an amendment with the federal government to add a $1.5 billion increase to the recently approved MCO tax. This would bring the total funding to approximately $20.9 billion. $12.9 billion of that amount would support Medi-Cal with the remaining $8 billion used for targeted rate increases/investments. While the Governor was optimistic about the ability to secure more funds by the federal government, an October 2023 LAO report for the current MCO tax stated, "According to DHCS, the federal government has indicated it may not approve such a large MCO tax again." As such, it will be interesting to see the federal government's appetite for adding another $1.5 billion to the previously approved MCO tax.

Health Care Worker $25/Hour Minimum Wage

The minimum wage bill for health care workers (SB 525) was signed into law by Governor Newsom in October 2023. It created three pay increase schedules based on provider type, ramping all workers in a covered health care entity to $25 per hour before 2030. The bill had been signed contingent on a "cleanup" bill to address several concerns because of significant anticipated state costs. That follow-up bill has not yet been introduced but is imminent.

The cost of this wage hike is not addressed in the proposed budget. As anticipated, the Administration is seeking revised legislation to add an annual "trigger" to make the wage increases subject to General Fund revenue availability, clarify the exemption for state facilities, and make other implementation clarifications. The "trigger" language is expected shortly, while the Governor has expressed his commitment to the ultimate implementation of the increase.

Propositions and Initiatives

Proposition 1 – "Treatment not Tents"

Proposition 1 proposes an overhaul of California's mental health funding system as well as a new $6.4 billion bond for facilities. Governor Newsom continues to publicly urge support for Prop 1 on the March 2024 ballot (treatmentnottents.com) and he secured CMA support on January 3.

The Public Policy Institute of California recently released a statewide survey showing that Prop 1 is supported by two in three (68%) likely voters. The highest support comes from the Counties of Los Angeles (73%), San Francisco (68%), Central Valley, Orange, and San Diego (67%), and the Inland Empire (65%). A protest at the Capitol is planned for February 1 by the opposition group (californiansagainstprop1.com), which appears to have little funding.

"Protect Access to Health Care Act of 2024" Ballot Initiative - MCO Tax

The "Coalition to Protect Access to Care" is currently working to collect approximately 550,000 signatures by the June 27 deadline to qualify for the November 2024 ballot. The California Secretary of State reported on January 12 that the initiative had collected 25% of signatures.

Initiative passage would be the first time the tax, which leverages federal reimbursement dollars, is made a permanent tax on health plans. All past MCO taxes (including the most recently approved tax in December 2023) have required legislation to seek approval by the federal government.

2023–24 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
S. 3430 Wyden (OR) Crapo (ID)	**Better Mental Health Care, Lower-Cost Drugs, and Extenders Act:** Would expand access to behavioral health services, reduce prescription drugs costs through pharmacy benefit manager (PBM) reforms and extend certain expiring provisions of the Medicare and Medicaid programs. Specific notable elements include but are not limited to the following: • Increasing all Medicare physician fee schedule payments by 2.5% (rather than 1.25%) for 2024 services. • Increasing Medicare physician fee schedule payments for certain behavioral health integration services in primary care settings during 2026–28. • Increasing Medicare bonus payments to providers that furnish mental health and substance use disorder (SUD) services in health professional shortage areas; expanding such bonus payments to include non-physician health care professionals. • Expanding access to behavioral telehealth services across state lines and for those with limited English proficiency. • Medicaid funding of up to seven days for services delivered to incarcerated individuals diagnosed with an SUD and pending disposition of charges. • Eliminating cuts to Medicaid disproportionate share hospital payments through September 30, 2025. Additionally, would include provisions from S. 3059, the Requiring Enhanced & Accurate Lists of (REAL) Health Providers Act, to require accurate provider directories on public websites updated every 90 days. ***Potential CalOptima Health Impact:*** Increased access to behavioral health services for CalOptima Health members; increased funding for contracted providers; increased staff oversight of CalOptima Health's OneCare provider directory.	**12/07/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
S. 923 Bennet (CO)	**Better Mental Health Care for Americans Act:** Would require parity for mental health services in Medicaid, Medicare Advantage (MA) and Medicare Part D. Would also enhance Medicaid and Medicare payments for integrating mental health and SUD 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)	**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 43 Eggman	**Gravely Disabled Definition:** Effective January 1, 2026, expands the definition of "gravely disabled" to include a condition resulting from a severe SUD, or a co-occurring mental health disorder and a severe SUD, as well as chronic alcoholism. Also requires the California Department of Health Care Services (DHCS) to submit a report to include the number of persons admitted or detained for grave disability. ***Potential CalOptima Health Impact:*** Increased oversight of CalOptima Health Medi-Cal members newly considered as gravely disabled.	**10/10/2023** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 326 Eggman	**The Behavioral Health Services Act:** Places this act on the March 5, 2024, statewide primary election ballot. If approved by voters, would rename the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA), expand services to include SUDs, revise the distribution of up to $36 million for behavioral health workforce funding and remove provisions related to innovative programs by, instead, establishing priorities and a program — administered by counties — to provide a housing support service. ***Potential CalOptima Health Impact****:* Increased resources and access to behavioral health services and housing interventions for CalOptima Health members.	**10/12/2023** Signed into law	CalOptima Health: Watch
SB 363 Eggman	**Behavioral Health Facilities Database:** No later than January 1, 2026, would require the 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 SUD treatment. ***Potential CalOptima Health Impact:*** Increased resources and access to behavioral health services for CalOptima Health Medi-Cal members.	**06/13/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/24/2023** Passed Senate floor	CalOptima Health: Watch
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.	**06/14/2023** Referred to Senate Health Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
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 SUD crisis. ***Potential CalOptima Health Impact*:** Increased efficiency and timeliness of facility referrals; decreased visits to the emergency department.	**01/19/2024** Died in Assembly Appropriations Committee **03/14/2023** Passed Assembly Health Committee	CalOptima Health: Watch
AB 531 Irwin	**The Behavioral Health Infrastructure Bond Act of 2023:** Places this bond act on the March 5, 2024, statewide primary election ballot. If approved by voters, would authorize $6.4 million in bonds to fund conversion, rehabilitation or new construction of supportive housing and community-based treatment facilities for those experiencing or at risk of homelessness and living with behavioral health challenges. ***Potential CalOptima Health Impact*:** Increased behavioral health services and community supports for some CalOptima Health members.	**10/12/2023** Signed into law	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.	**01/12/2024** Died in Assembly Health Committee	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 a psychiatric emergency medical condition, including screening examinations necessary to determine the presence or absence of an emergency medical condition — regardless of duration and whether the beneficiary was voluntarily or involuntarily admitted. ***Potential CalOptima Health Impact*:** Increased scope of behavioral health services for CalOptima Health Medi-Cal members.	**01/28/2024** Passed Assembly Appropriations Committee; referred to Assembly floor **01/09/2024** Passed Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1451 Jackson	**Urgent and Emergency Mental Health and SUD Treatment:** By January 1, 2024, would have required health plans to provide coverage for the treatment of urgent and emergency mental health and SUDs without prior authorization. ***Potential CalOptima Health Impact*:** Increased scope of and/or modified utilization management (UM) procedures for behavioral health services provided to CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed *(see **veto message**)*	CalOptima Health: Watch
AB 1470 Quirk-Silva	**Behavioral Health Documentation Standards:** Would require DHCS to standardize data elements relating to documentation requirements, including medically necessary criteria and develop standard forms containing information necessary to properly adjudicate claims. 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*:** New data requirements; additional training for CalOptima Health behavioral health staff on new documentation.	**09/12/2023** Passed Senate floor; referred to Assembly for concurrence in amendments **06/01/2023** Passed Assembly floor	CalOptima Health: Watch
Budget			
H.R. 2872 Granger (TX)	**Further Additional Continuing Appropriations and Other Extensions Act, 2024:** Enacts a third Continuing Resolution (CR) to further extend FY 2023 federal spending levels from January 19, 2024, through March 1, 2024, for certain agencies, and from February 2, 2024, through March 8, 2024, for other agencies. ***Potential CalOptima Health Impact:*** Continuation of current federal spending on programs impacting CalOptima Health members.	**01/19/2024** Signed into law	CalOptima Health: Watch
H.R. 5860 Granger (TX)	**Continuing Appropriations Act, 2024 and Other Extensions Act:** Enacts a CR to extend Fiscal Year (FY) 2023 federal spending levels from September 30 through November 17, 2023. ***Potential CalOptima Health Impact:*** Continuation of current federal spending on programs impacting CalOptima Health members.	**09/30/2023** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 6363 Granger (TX)	**Further Continuing Appropriations and Other Extensions Act, 2024:** Enacts a second CR to further extend FY 2023 federal spending levels from November 17, 2023, through either January 19, 2024, or February 2, 2024, depending on the funded agency. In addition, reauthorizes the Supplemental Nutrition Assistance Program (SNAP) — known as CalFresh in California — through FY 2024 ending on September 30, 2024. ***Potential CalOptima Health Impact:*** Continuation of current federal spending on programs impacting CalOptima Health members.	**11/16/2023** Signed into law	CalOptima Health: Watch
SB 101 Skinner **AB 102** Ting	**Budget Act of 2023:** Makes appropriations for the government of the State of California for FY 2023–24. Total spending is $310.8 billion, of which $226 billion is from the General Fund. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed FY 2023–24 Enacted State Budget Analysis.	**7/10/2023** Signed into law	CalOptima Health: Watch
AB 118 Committee on Budget	**Health Trailer Bill:** Consolidates and enacts certain budget trailer bill language containing the policy changes needed to implement health-related expenditures in the FY 2023-24 state budget. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed FY 2023–24 Enacted State Budget Analysis.	**07/10/2023** Signed into law	CalOptima Health: Watch
AB 119 Committee on Budget	**Managed Care Organization (MCO) Provider Tax Trailer Bill:** Renews the MCO provider tax, retroactively effective April 1, 2023, through December 31, 2026, and restructures the tax tiers and amounts. Also creates the Managed Care Enrollment Fund to fund Medi-Cal programs. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed FY 2023–24 Enacted State Budget Analysis.	**06/29/2023** Signed into law	CalOptima Health: Watch
California Advancing and Innovating Medi-Cal (CalAIM)			
AB 586 Calderon	**Community Support: Climate Change or Environmental Remediation Devices:** Would add "climate change or environmental remediation devices" 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, poor air quality or other climate events, including air conditioners, electric heaters, air filters and backup power sources. ***Potential CalOptima Health Impact:*** New services available for CalOptima Health Medi-Cal members to address social determinants of health (SDOH).	**01/19/2024** Died in Assembly Appropriations Committee **04/11/2023** Passed Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1338 Petrie-Norris	**Community Support: Fitness**: Would add fitness, physical activity, or recreational sports programs, activities, or memberships as a Community Support option. ***Potential CalOptima Health Impact:*** New services available for CalOptima Health Medi-Cal members to address SDOH.	**01/19/2024** Died in Assembly Appropriations Committee **04/18/2023** Passed Assembly Health Committee	CalOptima Health: Watch
Covered Benefits			
SB 257 Portantino	**Mammography:** Beginning January 1, 2025, would have required 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.	**10/07/2023** Vetoed *(see **veto message**)*	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.	**06/27/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/24/2023** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose
SB 339 Wiener	**Human Immunodeficiency Virus (HIV) Preexposure Prophylaxis (PrEP) and Postexposure Prophylaxis (PEP):** Would increase Medi-Cal coverage of PrEP and PEP furnished by a *pharmacist* from a 60-day maximum course to a 90-day maximum course, which could be further extended under certain conditions. ***Potential CalOptima Health Impact:*** Expanded Medi-Cal Rx benefit for CalOptima Health Medi-Cal members.	**01/22/2024** Senate concurred in amendments; ordered to the Governor **01/18/2024** Passed Assembly floor **05/22/2023** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose
SB 496 Limón	**Biomarker Testing:** No later than July 1, 2024, adds biomarker testing — subject to UM controls — 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, as prescribed. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**10/07/2023** Signed into law	CalOptima Health: Watch CAHP: Oppose Unless Amended

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 694 Eggman	**Self-Measured Blood Pressure (SMBP) Devices and Services**: Would have added two SMBP device-related services — patient training and device calibration as well as 30-day data collection — as covered Medi-Cal benefits to promote the health of beneficiaries with high blood pressure (hypertension) or another diagnosis that supports the use of an at-home blood pressure monitor. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed *(see **veto message**)*	CalOptima Health: Watch CalPACE: Support
AB 47 Boerner	**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.	**01/12/2024** Died in Assembly Health Committee	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 for the treatment of diabetes when medically necessary, subject to utilization controls. Would also allow DHCS to require a manufacturer of CGMs to enter into a rebate agreement with DHCS. ***Potential CalOptima Health Impact:*** Expanded covered benefits for CalOptima Health Medi-Cal members.	**08/21/2023** Re-referred to Senate floor **06/21/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch CalPACE: Support
AB 425 Alvarez	**Pharmacogenomics Advancing Total Health for All Act:** Effective July 1, 2024, adds 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:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**10/07/2023** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 608 Schiavo	**Perinatal Services**: Would have required DHCS to cover additional perinatal assessments, individualized care plans and other services during the one-year postpartum Medi-Cal eligibility period at least proportional to those available during pregnancy and the initial 60-day postpartum period. DHCS would have been required to collaborate with the California Department of Public Health (CDPH) and stakeholders to determine the specific levels of additional coverage. Would have also allowed perinatal services to be rendered by a nonlicensed perinatal health worker in a beneficiary's home or other community setting away from a medical site. Lastly, would have allowed such workers to be supervised by a community-based organization or local health jurisdiction. ***Potential CalOptima Health Impact:*** Expanded covered benefit and associated provider network for CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed *(see veto message)*	CalOptima Health: Watch
AB 847 Rivas, L.	**Pediatric Palliative Care Services**: Authorizes extended Medi-Cal coverage for palliative care and hospice services after 21 years of age for individuals deemed eligible prior to that age. ***Potential CalOptima Health Impact:*** Expanded covered benefit for certain CalOptima Health Medi-Cal members.	**10/13/2023** Signed into law	CalOptima Health: Watch
AB 907 Lowenthal	**PANDAS and PANS**: Beginning January 1, 2024, would have required a health plan to provide coverage for prophylaxis, diagnosis and 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.	**10/07/2023** Vetoed *(see veto message)*	CalOptima Health: Watch CAHP: Oppose
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.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1060 Ortega	**Naloxone:** Would have added prescription and non-prescription naloxone hydrochloride or another drug approved by the U.S. Food and Drug Administration as a covered benefit under the Medi-Cal program for the complete or partial reversal of an opioid overdose. ***Potential CalOptima Health Impact:*** New Medi-Cal Rx benefit for CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed *(see **veto message**)*	CalOptima Health: Watch CAHP: Oppose Unless Amended
AB 1085 Maienschein	**Housing Support Services**: Would have required DHCS, if the state has sufficient network capacity, 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.	**10/07/2023** Vetoed *(see **veto message**)*	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.	**01/19/2024** Died in Assembly Appropriations Committee **04/25/2023** Passed Assembly Health 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
AB 1481 Boerner	**Medi-Cal Presumptive Eligibility for Pregnancy**: Expands Medi-Cal presumptive eligibility for pregnant women to all pregnant people, renaming the program "Presumptive Eligibility for Pregnant People" (PE4PP). If an application for full-scope Medi-Cal benefits is submitted between the date of a PE4PP determination and the last day of the subsequent month, PE4PP coverage will 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.	**10/07/2023** Signed into law	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.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1783 Essayli	**Unsatisfactory Immigration Status:** States the intent of the Legislature to enact legislation to prohibit state funding of health care benefits for individuals with unsatisfactory immigration status. ***Potential CalOptima Health Impact:*** Decreased number of CalOptima Health members	**01/04/2024** Introduced	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 exempt from work requirements.	**04/26/2023** Passed House floor; referred to Senate Budget Committee	CalOptima Health: Concerns ACAP: Oppose
SB 770 Wiener	**Unified Health Care Financing System:** Directs the CalHHS Secretary to research, develop and pursue discussions of a waiver framework with the federal government to create a health care system that incorporates a comprehensive package of medical, behavioral health, pharmacy, dental and vision benefits, without a share of cost for essential services. No later than January 1, 2025, the Secretary must submit an interim report to the Legislature, including proposed statutory language to authorize submission of a waiver application. No later than June 1, 2025, a draft waiver framework must be completed and made available to the public for a 45-day public comment period. No later than November 1, 2025, the finalized waiver framework must be submitted to the governor and Legislature for review. ***Potential CalOptima Health Impact:*** Unknown but potentially significant impacts to the Medi-Cal and commercial health care delivery systems, including changes to administration, covered benefits, financing and organization.	**10/07/2023** Signed into law	CalOptima Health: Watch
AB 557 Hart	**Brown Act Flexibilities:** Permanently extends current Brown Act teleconferencing flexibilities — when a declared state of emergency is in effect — beyond January 1, 2024. Also extends 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.	**10/08/2023** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 719 Boerner	**Public Transit Contracts**: Would have required Medi-Cal managed care plans to contract with public paratransit operators for nonmedical transportation (NMT) and nonemergency medical transportation (NEMT) services. Would have required 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.	**10/07/2023** Vetoed *(see veto message)*	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose
AB 1202 Lackey	**Health Care Services Data for Children, Pregnancy and Postpartum:** No later than January 1, 2025, would have required DHCS to report to the Legislature 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. The report would have also included data on the number of children, pregnant and postpartum individuals receiving certain Medi-Cal services. ***Potential CalOptima Health Impact:*** Increased network analysis and reporting to DHCS.	**10/08/2023** Vetoed *(see veto message)*	CalOptima Health: Watch
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 and commercial health care delivery systems, including changes to administration, covered benefits, financing and organization.	**01/19/2024** Died without referral to committee	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

Bill Number Author	Bill Summary	Bill Status	Position/Notes
S. 1703 Carper (DE) **H.R. 3549** Wenstrup (OH)	**Program of All-Inclusive Care for the Elderly (PACE) Part D Choice Act of 2023:** Would allow a Medicare-only PACE participant to opt out of drug coverage provided by the PACE program and instead enroll in a standalone Medicare Part D prescription drug plan that results in equal or lesser out-of-pocket costs. PACE programs would be required to educate their participants about this option. ***Potential CalOptima Health Impact:*** Increased enrollment into CalOptima Health PACE by Medicare-only beneficiaries due to decreased out-of-pocket costs.	**05/18/2023** Introduced; referred to committees	**08/30/2023** CalOptima Health: SUPPORT NPA: Support
SB 311 Eggman	**Medicare Part A Buy-In:** Requires DHCS to submit a Medicaid state plan amendment to enter into a Medicare Part A buy-in agreement with CMS, effective January 1, 2025, or DHCS's readiness date, whichever is later. This will 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.	**10/10/2023** Signed into law	CalOptima Health: Watch LHPC: Support CalPACE: Support
AB 1022 Mathis	**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.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
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.	**01/12/2024** Died in 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.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch LHPC: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Providers			
S. 3059 Bennet (CO)	**Requiring Enhanced & Accurate Lists of (REAL) Health Providers Act:** Effective plan year 2026, would require MA plans to update and ensure accurate provider directory information at least once every 90 days. If a plan is unable to verify such information for a specific provider, a disclaimer indicating that the information may not be up to date is required. Would also require the removal of a provider from a directory within five business days if the plan determines they are no longer participating in the network. ***Potential CalOptima Health Impact:*** Increased staff oversight of CalOptima Health's OneCare provider directory.	**10/17/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
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 **SB 516** Skinner	**Prior Authorization "Gold Carding"**: Beginning January 1, 2026, 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. Would also broadly prohibit prior authorization requirements for any services approved by a health plan at least 95% of the time. ***Potential CalOptima Health Impact:*** Implementation of new UM procedures to assess provider approval rates; decreased number of prior authorizations.	**09/14/2023** SB 516 gutted and amended as new vehicle for SB 598; re-referred to Assembly Appropriations Committee **07/11/2023** Passed Assembly Health Committee **05/25/2023** Passed Senate floor	**08/30/2023** CalOptima Health: OPPOSE CAHP: Oppose LHPC: 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 CDPH. ***Potential CalOptima Health Impact:*** Expansion of intermittent and mobile health care sites; increased access to care for CalOptima Health members.	**08/16/2023** Passed Assembly Appropriations Committee; referred to Assembly floor **07/11/2023** Passed 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.	**01/18/2024** Passed Assembly Appropriations Committee; referred to Assembly floor **03/14/2023** Passed Assembly Health 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.	**06/14/2023** Referred to Senate Health Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch
AB 815 Wood	**Provider Credentialing**: 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.	**06/07/2023** Referred to Senate Health Committee **05/30/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Concerns LHPC: Oppose Unless Amended
AB 904 Calderon	**Doula Access**: Beginning January 1, 2025, requires 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.	**10/07/2023** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 931 Irwin	**Physical Therapy Prior Authorization**: Beginning January 1, 2025, would have prohibited 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.	**10/07/2023** Vetoed *(see **veto message**)*	CalOptima Health: Watch CAHP: Oppose
AB 1241 Weber	**Medi-Cal Telehealth Access:** Requires Medi-Cal telehealth providers to maintain and follow protocols to either offer in-person services or arrange a referral to in-person services. However, this does 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.	**09/08/2023** Signed into law	CalOptima Health: Watch
AB 1288 **AB 1842** Reyes	**Medication-Assisted Treatment Prior Authorization**: Would have prohibited health plans from requiring prior authorization for a naloxone product, buprenorphine product, methadone or long-acting injectable naltrexone for detoxification or maintenance treatment of an SUD, when prescribed according to generally accepted national professional guidelines. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**01/16/2024** Re-introduced as AB 1842 **10/08/2023** Vetoed as AB 1288 *(see **veto message**)*	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
S. 1038 Welch (VT) **H.R. 1613** Carter (GA)	**Drug Price Transparency in Medicaid Act of 2023:** Would prohibit "spread pricing" for payment arrangements with PBMs under Medicaid. Would also require a pass-through pricing model that focuses on cost-based pharmacy reimbursement and dispensing fees. ***Potential CalOptima Health Impact*:** Lower costs and increased transparency in drug prices under the Medi-Cal Rx program,	**03/29/2023** Introduced; referred to committees	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
S. 3578 Cassidy (LA)	**Protect Medicaid Act:** Would prohibit federal funding for the administrative costs of providing Medicaid benefits to individuals with unsatisfactory immigration status. If states choose to self-fund such costs, this bill would require states to submit a report describing its funding methods as well as the process utilized to bifurcate its expenditures on administrative costs. ***Potential CalOptima Health Impact:*** New financial reporting requirements.	**01/11/2024** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
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.	**03/24/2023** 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.	**07/11/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/25/2023** Passed 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.	**06/15/2023** Referred to Assembly Health Committee and Assembly Public Safety Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 525 Durazo	**Health Care Workers Minimum Wage:** Establishes three separate minimum wage schedules for covered health care employers, including integrated health care delivery systems; health care systems; dialysis clinics; health facilities owned, affiliated, or operated by a county; licensed skilled nursing facilities; and clinics that meet certain requirements. ***Potential CalOptima Health Impact:*** Increased direct wage costs for certain CalOptima Health PACE employees to be incorporated into DHCS rates; increased indirect costs from contracted providers subject to wage increases**.**	**10/13/2023** Signed into law	CalOptima Health: Watch
SB 870 Caballero	**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.	**01/19/2024** Died in Senate Appropriations Committee **04/26/2023** Passed Senate Health 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.	**01/19/2024** Died in Assembly Appropriations Committee **04/25/2023** Passed Assembly Health Committee	CalOptima Health: Watch
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.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 576 Weber	**Abortion Reimbursement**: Would have required 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.	**10/07/2023** Vetoed *(see **veto message**)*	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
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, including staffing, 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.	**01/19/2024** Died in Assembly Appropriations Committee **04/25/2023** Passed Assembly Health 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.	**01/19/2024** Died without referral to committee	CalOptima Health: Watch
Social Determinants of Health			
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
H.R. 3746 McHenry (NC)	**Fiscal Responsibility Act (FRA) of 2023:** Suspends the $31 trillion debt limit until January 1, 2025, and includes additional policies to cap discretionary spending limits and modify work reporting requirements for certain safety net programs. Most notably, modifies work requirements for SNAP. Specifically, through October 1, 2030, raises the age of SNAP recipients subject to work requirements from 18–49 to 18–55 years old but also creates new exemptions that waive SNAP work requirements for veterans, individuals experiencing homelessness and young adults ages 18–24 years old who are aging out of the foster care system. ***Potential CalOptima Health Impact:*** Increased number of CalOptima Health members eligible for CalFresh.	**06/03/2023** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 85 Weber	**SDOH Screenings:** Would have added SDOH screenings as a covered Medi-Cal benefit. Would have also required health plans to provide primary care providers with adequate access to community health workers, social workers and peer support specialists. Would have also required 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.	**10/07/2023** Vetoed *(see **veto message**)*	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.	**01/19/2024** Died in Assembly Public Safety Committee **03/07/2023** Failed passage in Assembly Public Safety Committee	CalOptima Health: Watch
AB 271 Quirk-Silva	**Homeless Death Review Committee:** Authorizes 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.	**09/01/2023** Signed into law	**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
SNP Alliance: Special Needs Plan Alliance

Last Updated: January 22, 2024

2024 Federal Legislative Dates

January 8	118th Congress, 2nd Session convenes
August 5–September 6	Summer recess
September 30–November 11	Fall recess
December 20	118th Congress adjourns

Source: Floor Calendars, United States Congress: https://www.congress.gov/calendars-and-schedules

2024 State Legislative Dates

January 3	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
January 12	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2023
January 19	Last day for any committee to hear and report to the floor any bill introduced in that house in 2023
January 31	Last day for each house to pass bills introduced in that house in 2023
February 16	Last day for legislation to be introduced in 2024
March 21–March 30	Spring recess
April 26	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2024
May 3	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house in 2024
May 17	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house in 2024
May 20–24	Floor session only
May 24	Last day for each house to pass bills introduced in that house in 2024
June 15	Budget bill must be passed by midnight
July 3	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 3–August 4	Summer recess
August 16	Last day for fiscal committees to report bills in their second house to the Floor
August 19–31	Floor session only
August 23	Last day to amend bills on the Floor
August 31	Last day for each house to pass bills; final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2024 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).

FY 2023–24 Enacted State Budget Analysis

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Background

On January 10, 2023, Gov. Gavin Newsom released the Fiscal Year (FY) 2023–24 Proposed State Budget, effective July 1, 2023. The proposed budget's total spending of $297 billion ($223.6 billion General Fund [GF]) reflected an estimated $22.5 billion deficit and a 9.8% decrease in overall spending compared to the FY 2022–23 Enacted Budget.

On May 12, Gov. Newsom released the FY 2023–24 Revised Budget Proposal, also known as the May Revise, with total funding at $306 billion, including $224 billion GF. As tax revenues continued to decline, the projected budget deficit increased by $9.3 billion compared to January Proposed Budget — totaling a $31.5 billion deficit. Nevertheless, the governor continued to present a balanced budget — largely without program cuts — through spending delays, shifts to funding sources, pullbacks of unused expenditures, new revenue sources, borrowing and limited reserve withdrawal.

To meet the constitutionally obligated deadline to pass a balanced budget, on June 15, the State Senate and State Assembly both passed Senate Bill (SB) 101, a placeholder budget representing the Legislature's joint counterproposal to the May Revise. Once a final budget agreement deal was reached between the governor and legislative leaders, the governor signed into law the placeholder state budget (SB 101) on June 27 and the final, agreed-upon budget revisions (Assembly Bill [AB] 102) on July 10. In addition to the budget, the governor also signed the Managed Care Organization (MCO) Tax Trailer Bill (AB 119) on June 29 and the consolidated Health Trailer Bill (AB 118) on July 10, which contain the policy changes needed to implement health-related budget expenditures. Together, these bills represent the FY 2023–24 Enacted Budget.

Overview

As the second largest budget in California history, the FY 2023–24 Enacted Budget sits at $310.8 billion, including nearly $226 billion GF spending, which attempts to close the gap on a $32 billion deficit while safeguarding $37.8 billion in reserve funds. This represents a 4.4% decrease in GF spending compared to the FY 2022–23 Enacted Budget ($234.4 billion GF). To achieve a balanced budget this FY, certain commitments will be delayed or added to the FY 2024–25 budget as a future investment.

The enacted budget estimates Medi-Cal spending of $151.2 billion ($37.6 billion GF), an 11.7% total increase (21.7% GF increase) from FY 2022–23, despite the fact that average Medi-Cal caseload in FY 2023–24 is expected to decrease by 7.2% to 14.2 million beneficiaries

as redeterminations resume following the end of the COVID-19 public health emergency (PHE). Total COVID-19-specific impacts on the Medi-Cal budget impacts are projected to decline overall, but GF costs are predicted to increase due to the phase-out of federal relief funding related to the PHE.

Managed Care Organization (MCO) Provider Tax

With renewed commitments to Medi-Cal spending, the enacted budget retroactively implements a new MCO Provider Tax, effective April 1, 2023, through December 31, 2026. Over the period of the tax, a total of $19.4 billion in net benefits will be generated — with $8.3 billion allocated for GF offsets to support a balanced budget and the remaining $11.1 billion for historic new investments in the Medi-Cal program, including targeted increases to Medi-Cal rates, access and provider participation.

In facilitating the $11.1 billion allocation, the new Medi-Cal Provider Payment Reserve Fund will support investments in Medi-Cal that maintain and expand programs by increasing quality of health care delivery and reducing barriers to care. These funds will preserve eligibility and benefit expansions in the Medi-Cal program, strengthen the program's participation, especially in underserved areas and in primary and preventive care, and maximize opportunities to draw additional federal matching funds to the Medi-Cal program. While a detailed plan for most investments will be submitted as part of the FY 2024–25 budget next year, specific limited investments beginning in FY 2023–24 can be found below:

Rate Increases in the Medi-Cal Program: No sooner than January 1, 2024, reimbursement rates for primary care services (including nurse practitioners and physician assistants), maternity care (including obstetric and doula services), and certain outpatient non-specialty mental health services will increase to at least 87.5% of Medicare rates. This is an adjustment to base rates that takes into account current Proposition 56 supplemental payments and the elimination of AB 97 rate reductions for these services. Estimated costs to increase provider rates are $237.4 million ($98.2 million Medi-Cal Provider Payment Reserve Fund) in FY 2023–24 and $580.5 million ($240.1 million Medi-Cal Provider Payment Reserve Fund) annually thereafter.

Distressed Hospital Loan Program: $300 million is allocated to support not-for-profit and public hospitals facing closure or facilitating the reopening of a hospital. The Department of Health Care Access and Information (HCAI) and California Health Facilities Financing Authority will provide one-time interest-free cashflow loans of up to $150 million from the Medi-Cal Provider Payment Reserve Fund in FY 2023–24 and up to $150 million from the GF in the previous FY 2022–23 to distressed hospitals in need.

Small and Rural Hospital Relief Program: $52.2 million will support rural hospitals to meet compliance standards with the State's seismic mandate with $50 million one-time from the Medi-Cal Provider Payment Reserve and $2.2 million from the Small and Rural Hospital Relief Fund for assessment and construction.

Graduate Medical Education Program: In an effort to increase the number of primary and specialty care physicians in the state — based on demonstrated workforce needs and priorities — $75 million will be expended for the University of California to expand graduate medical education programs and annually thereafter.

Behavioral Health

The state budget continues to address gaps through renewed commitments to modernize current programs in the mental health continuum. The enacted budget includes $40 million ($20 million Mental Health Services Fund; $20 million federal funds) to continue reforming the behavioral health system. As part of the final budget agreement, DHCS will work to implement the governor's proposal to modernize the Mental Health Services Act as well as authorize a general obligation bond to fund the following:

- Unlocked community behavioral health residential settings
- Permanent supportive housing for people experiencing or at risk of homelessness who have behavioral health conditions
- Housing for veterans experiencing or at risk of homelessness who have behavioral health conditions

988 Suicide and Crisis Program: $13.2 million in special funds and federal funds will support a five-year implementation plan for a comprehensive 988 system. Under the health trailer bill language, prior authorization will no longer be required for behavioral health crisis stabilization services and care but authorizes prior authorization for medically necessary mental health or substance use disorder services following stabilization from a behavioral health crisis provided through the 988 system. Additionally, a plan that provides behavioral health crisis services and is contacted by a 988 center or mobile crisis team must authorize post-stabilization care or arrange for prompt transfer of care to another provider within 30 minutes

of initial contact.

Children and Youth Behavioral Health Initiative (CYBHI) Fee Schedule Third Party Administrator (TPA): As part of the CYBHI mandate, an established statewide all-payer fee schedule will reimburse school-linked behavioral health providers who deliver services to students at or near a school-site. $10 million from the Mental Health Services Fund will be expended in support of the statewide infrastructure that will consolidate provider management operations to include credentialing, quality assurance, billing and claims.

CalHOPE: The CalHOPE program is a vital element of the statewide crisis support system. $69.5 million total funding will assist in continuing operations, including media messaging to destigmatize stress and anxiety as well as CalHOPE web services, warm line and partnership opportunities with up to 30 community-based organizations and over 400 peer crisis counselors.

CalFresh

CalFresh — California's implementation of the federal Supplemental Nutrition Assistance Program (SNAP) — sees $35 million in funding for the California Nutrition Incentive Program, which helps members purchase healthy food from farmers' markets. The Legislature also included a line item for $16.8 million in one-time funding to extend the sunset dates for a CalFresh fruit and vegetable pilot EBT program Market Match. For every benefit dollar spent, participants receive an additional dollar to spend on fruits and vegetables at a market within set parameters. The deal also includes $915,000 to trial monthly minimum CalFresh benefit increase from $23 to $50.

California Advancing and Innovating Medi-Cal (CalAIM)

Transitional Rent: DHCS successfully sought an amendment to the CalAIM Transitional Rent Waiver with a commitment of $17.9 million ($6.3 million GF) for an additional community support that may be offered by Medi-Cal MCPs. Under the DHCS budget, the new "Transitional Rent" community support would allow the provision of up to six months of rent or temporary housing to eligible individuals experiencing homelessness or at risk of homelessness and transitioning out of institutional levels of care, a correctional facility, or the foster care system.

Relatedly, the budget also includes an additional $40 million GF for the Provider Access and Transforming Health (PATH) initiative to assist providers with implementing community supports and enhanced care management (ECM) through CalAIM in clinics.

Justice Involved: CalAIM receives a commitment of $9.9 million total funding ($3.8 million GF) in FY 2023–24 for pre-release services, with an additional $225 million estimated subsidy through the PATH program to support correctional agencies in collaborating with county social services department planning and implementation of pre-release Medi-Cal enrollment services.

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT): Formerly referred to as the California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration, BH-CONNECT receives $6.1 billion total ($306.2 million GF; $87.5 million Mental Health Services Fund; $2.1 billion Medi-Cal County Behavioral Health Fund; $3.6 billion federal funds) over a span of five years for DHCS and the California Department of Social Services (DSS) to implement this CalAIM program as soon as January 1, 2024. BH-CONNECT includes statewide and county opt-in components, including rent and temporary housing for up to six months for certain high-needs beneficiaries as well a behavioral health workforce initiative to expand provider capacity and services. DHCS will also seek federal approval of a Medicaid Section 1115 demonstration waiver to expand behavioral health services for Medi-Cal members living with serious mental illness and serious emotional disturbance.

As part of CalAIM Behavioral Health Payment Reform, the budget also provides $250 million GF one-time to support the non-federal share of behavioral health-related services. These funds will help mitigate a significant cash flow concern for counties as they transition from cost-based reimbursement to a fee schedule.

Community Assistance, Recovery and Empowerment (CARE) Act

With a renewed pledge to serve California's most severely impaired population who often struggle with homelessness or incarceration without treatment, the CARE Act receives funding of $52.3 million GF in FY 2023–24, $121 million GF in FY 2024-25 and $151.5 million GF in FY 2025–26 to support ongoing county behavioral health department costs. The CARE Act facilitates delivery of mental health and substance use disorder services to individuals with schizophrenia spectrum or other psychotic disorders who lack medical decision-making competences. The program would connect a person in crisis with a court-ordered

care plan for up to 24 months as a diversion from homelessness, incarcerations, or conservatorship.

Medi-Cal Eligibility

Enrollment Navigators: In addition to the $60 million appropriated in FY 2022–23, $10 million from the GF will be invested into the Health Enrollment Navigators Project (AB 74) over four years. The project aims to promote outreach, enrollment and retention activities in vulnerable populations through partnerships with counties and community-based organizations. Target populations of priority include but are not limited to persons with mental health disorder needs, persons with disabilities, older adults, unhoused individuals, young people of color, immigrants and families of mixed immigration status.

Medi-Cal Expansion to Undocumented Individual: The enacted budget maintains $1.4 billion ($1.2 billion GF) in FY 2023–24 and $3.4 billion ($3.1 billion GF) at full operation, inclusive of In-Home Supportive Services (IHSS) costs, to expand full-scope Medi-Cal eligibility to all income-eligible adults ages 26–49, regardless of immigration status, on January 1, 2024.

Newborn Hospital Gateway: The Newborn Hospital Gateway system provides presumptive eligibility determinations through an electronic process for families to enroll a deemed eligible newborn into the Medi-Cal program from hospitals that elected to participate in the program. Effective July 1, 2024, all qualified Medi-Cal providers participating in presumptive eligibility programs must utilize the Newborn Hospital Gateway system via the Children's Presumptive Eligibility Program portal to report a Medi-Cal-eligible newborn born in their facilities within 72 hours after birth or one business day after discharge.

Whole Child Model (WCM): As part of the budget, WCM will be extended to 15 additional counties no sooner than January 1, 2025. Currently implemented in 21 counties, WCM integrates children's specialty care services provided in the California Children's Services (CCS) program into Medi-Cal managed care plans (MCPs). WCM is already implemented in Orange County. The budget also requires a Medi-Cal MCP participating in WCM to ensure that a CCS-eligible child has a primary point of contact that will be responsible for the child's care coordination and support the referral pathways in non-WCM counties.

Miscellaneous

The enacted budget includes several other adjustments and provisions that potentially impact CalOptima Health:

- **COVID-19 Response:** a one-time funding of $126.6 million will continue ongoing efforts to protect the state's public health against COVID-19 – including maintenance of reporting systems, lab management and CalCONNECT — for oversight case and outbreak investigation.
- **Hepatitis C Virus Equity:** $10 million one-time GF spending, spanning over five years, to expand Hepatitis C Virus services — including outreach, linkage and testing — among high priority populations including young people who use drugs, indigenous communities and those experiencing homelessness.
- **Medi-Cal Rx Naloxone Access Initiative:** a one-time $30 million Opioid Settlements Fund expenditure to support the creation or procurement of a lower cost generic version of naloxone nasal product.
- **Medi-Cal Rx Reproductive Health Costs:** a one-time $2 million GF reappropriation and permissive use of funds for reproductive health care – including statutory changes to provide flexibility for the Medi-Cal Rx program to acquire various pharmaceutical drugs — Mifepristone or Misoprostol — to address urgent and emerging reproductive health needs.
- **Public Health Workforce:** upholds $97.5 million GF over four years for various public health workforce training and development programs.
- **Reproductive Waiver:** $200 million total funds to implement the Reproductive Health Services 1115 demonstration waiver that will support access to family planning and related services for Medi-Cal members as well as support sustainability and system transformation for California's reproductive health safety net.

Next Steps

State agencies will begin implementing the policies included in the enacted budget. Staff will continue to monitor these polices and provide updates regarding issues that have a significant impact to CalOptima Health. In addition, the Legislature will continue to advance policy bills through the legislative process.

Bills with funding allocated in the enacted budget are more likely to be passed and signed into law. The Legislature has until September 14 to pass legislation, and Gov. Newsom has until October 14 to either sign or veto that legislation.

About CalOptima Health

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

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

CalOptima Health Community Outreach Summary — January and February 2024

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. Participation includes providing Medi-Cal educational materials and, if criteria is met, financial support and/or CalOptima Health-branded items.

CalOptima Health's participation in public activities promotes:

- Member interaction/enrollment in a CalOptima Health program
- Community awareness of CalOptima Health
- Partnerships that increase positive visibility and relationships with community organizations

Community Outreach Highlight

Throughout 2023, CalOptima Health continued to make a tangible difference in the lives of our members and community by participating in or hosting 187 community events and contributing a total of $125,085 in sponsorships. These dedicated outreach efforts impacted more than 16,175 community members.

The Community Relations team spearheaded four Medi-Cal Renewal and CalFresh Enrollment Events in collaboration with 112 community partners, ensuring access to essential community resources to support our members' comprehensive needs. At these events, 1,790 diaper boxes and 3,040 food boxes were distributed.

We hosted our inaugural Back-to-School event, where we served more than 3,000 children and their families. The event provided services at no-cost to attendees, including 60 haircuts, 60 dental screenings, 30 sports physicals, 102 vision screenings and 98 eyeglasses. We also distributed 1,100 backpacks and 1,308 school supply kits, so students would have the tools they need to succeed at school. In addition, we provided 300 pairs of sunglasses, 540 bike helmets, and served 1,185 taco meals.

CalOptima Health will expand our outreach efforts in 2024 to further support Medi-Cal renewals as well as the Ages 26 Through 49 Adult Full Scope Medi-Cal Expansion and other critical initiatives impacting our members and communities.

Summary of Public Activities

As of January 23, CalOptima Health plans to participate in, organize or convene 61 public activities in January and February. In January, there were 26 public activities, including 15 virtual community/collaborative meetings, four community-based presentations, six community events and one Health Network Forum. In February there will be 35 public activities, including 17 virtual community/collaborative meetings, two

community-based presentations, 13 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 two 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. Letter of support for Orange County Department of Education's HOPES Collaborative to support outreach and education support for students without permanent housing.
2. Letter of support for the Multi-Ethnic Collaboratives of Community Agencies for the Road to Resilience funding opportunity to help pregnant women and families affected by substance use.

For additional information or questions, contact CalOptima Health Community Relations Director Tiffany Kaaiakamanu at 714-222-0637 or tkaaiakamanu@caloptima.org.

CalOptima Health

Attachment to the February 1, 2024, CalOptima Health Outreach Summary

Community events hosted by CalOptima Health and community partners in January and February 2024:

January 2024

January 17, 7:30–9:30 a.m., CalOptima Health Medi-Cal Overview in English

Champions at Franklin Elementary, 521 W. Water St., Anaheim

- At least one staff member presented (in-person).
- Community-based organization presentation, open to members/community.

January 17, 9 a.m.–1 p.m., Spring 2024 Involvement Fair, hosted by Saddleback College

Saddleback College, 28000 Marguerite Pkwy., Mission Viejo

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

January 18, 4–5:30 p.m., Anaheim Mobile FRC, hosted by Anaheim Neighborhood and Human Services

Saddleback High School, 932 S. Roberts St., Anaheim

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

January 18, 8:30–9:30 a.m., CalOptima Health Medi-Cal Overview in Spanish

Washington Elementary School, 910 W. Anahurst Pl., Santa Ana

- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community.

January 19, 9–10 a.m., CalOptima Health Medi-Cal Overview in English

Minnie Street FRC, virtual

- At least one staff member presented.
- Community-based organization presentation, open to members/community.

January 19, 10 a.m.–2 p.m., U.S. Colleges Resource Fair, hosted by U.S. Colleges Santa Ana Campus

U.S. Colleges Santa Ana, 1840 E. 17 St., Santa Ana

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

January 19–20, 8 a.m.–2 p.m., 3rd Ibero-American Parkinson's Conference, hosted by Give for A Smile

Virtual

- Sponsorship fee: $1,500; included logo on printed materials and on webpage.
- At least one staff member attended.
- Health/resource fair, open to the public.

January 20, 10 a.m.–4 p.m., The Home of Our Ancestors, hosted by Santa Ana Unified School District (SAUSD)

Saddleback High School, 2802 S. Flower St., Santa Ana

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

January 23, 9 a.m.–1 p.m., Spring 2024 Involvement Fair, hosted by Saddleback College

Saddleback College, 28000 Marguerite Pkwy., Mission Viejo

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

January 24, 8:30–9:30 a.m., CalOptima Health Medi-Cal Overview in Spanish

John Muir Fundamental, 1951 Mabury St., Santa Ana

- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community.

January 26, 2–6 p.m., Community Resource Fair, hosted by CalOptima Health, County of Orange Social Services Agency (SSA) and Orange County United Way

Anaheim Central Library, 500 W. Broadway, Anaheim

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

February 2024

February 1, 7:40–8:40 a.m., CalOptima Health Medi-Cal Overview in Spanish

James Madison Elementary, virtual

- At least one staff member presented.
- Community-based organization presentation, open to members/community.

February 3, 9 a.m.–4 p.m., 43rd Orange County Black History Parade and Unity Festival, hosted by the Orange County Heritage Council

Downtown Anaheim, 205 W. Center St., Anaheim

- Registration fee: $175 includes resource table at event.
- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

February 6, 9 a.m.–1 p.m., Spring 2024 Involvement Fair, hosted by Saddleback College
Saddleback College, 28000 Marguerite Pkwy., Mission Viejo

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

February 9–11, 10 a.m.–10 p.m., Tet Festival, hosted by Union of Vietnamese Student Associations of Southern California (UVSA)
OC Fair and Event Center, 88 Fair Dr., Costa Mesa

- Sponsorship fee: $12,000; includes resource table at event, logo and link on event website for one year, social media post, 40 admission tickets, four three-day admission and parking badges, three banner displays, graphic ad on main stage, and half-page ad in event program book.
- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

February 9-11, 11 a.m.–10 p.m., Tet Festival, hosted by Viet American Society
Mile Square Park, 16801 Euclid St., Fountain Valley

- Registration fee: $1,600; includes resource table at event.
- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

February 10, 9 a.m.–2:30 p.m., Love Shouldn't Hurt, hosted by Human Options
Early College Highschool, 2990 Mesa Verde Dr. E, Costa Mesa

- Sponsorship fee: $2,000; includes resource table at event.
- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

February 13, 4 –5:30 p.m., Anaheim Mobile FRC, hosted by Anaheim Neighborhood and Human Services
Anna Drive, Anaheim

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

February 15, 4–5:30 p.m., Anaheim Mobile FRC, hosted by Anaheim Neighborhood and Human Services
Cabot St., Anaheim

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

February 16, 2:30–6:30 p.m., We Care Wellness and Education Fair, hosted by SAUSD
Saddleback High School, 2802 S. Flower St., Santa Ana

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

February 21, 11 a.m.–Noon, CalOptima Health Medi-Cal Overview in English
Nicholas Academic Center, 324 W. 4th St., Santa Ana

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

- At least one staff member to present (in-person).
- Community-based organization presentation, open to members/community.

February 22, 4–5:30 p.m., Anaheim Mobile FRC, hosted by Anaheim Neighborhood and Human Services

Mayfair/Lodge, Anaheim

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

February 22, 7 a.m.–5:30 p.m., 2024 Health Care Forecast Conference, hosted by UCI Paul Merage School of Business

The Beckman Center, 100 Academy Way., Irvine

- Sponsorship fee: $5,000; includes resource table at event, logo on social media posts, marketing materials, conference app and website, three complimentary registrations, and webinar.
- At least four staff members to attend (in person).
- Health/resource fair, open to the public.

February 24, 10 a.m. –3 p.m., Veterans Stand Down, hosted by the Orange Coast District Elks

Garden Grove Elks Lodge, 11551 Trask Ave., Garden Grove

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

February 27, 4 –5:30 p.m., Anaheim Mobile FRC, hosted by Anaheim Neighborhood and Human Services

Baxter/Romneya, Anaheim

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

February 27, 9–10:30 a.m., Cafecito Meeting, hosted by CalOptima Health

Virtual

- At least eight staff members to attend.
- Health/resource fair, open to the public.

February 29, 4–5:30 p.m., Anaheim Mobile FRC, hosted by Anaheim Neighborhood and Human Services

Guinada Lane, Anaheim

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

These sponsorship request(s) and community event(s) met the requirements of CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at:
https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation
Exhibitor/Attendee

CalOptima Health Board Action Agenda Referral

Action To Be Taken February 1, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
15. Authorize Actions Related to the Medi-Cal School Mental Health Provider Contracts

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

Recommended Actions
1. Authorize the Chief Executive Officer to execute Medi-Cal Professional Services Contracts with Orange County's School Districts for school mental health services, effective January 1, 2024; and
2. Authorize unbudgeted expenditures and appropriate funds from existing reserves for Medi-Cal-covered school mental health services in an amount up to $750,000 for the period of January 1, 2024, through June 30, 2024.

Background
On December 22, 2023, the Department of Health Care Services (DHCS) posted the draft rates for the Children and Youth Behavioral Health Initiative (CYBHI) Statewide Multi-Payer fee schedule (CYBHI Fee Schedule). DHCS, in collaboration with the Department of Managed Health Care and the California Department of Insurance, is expanding access to outpatient non-specialty mental health services provided to students 25 years of age or younger by public local educational agencies (LEAs), institutions of higher education (community colleges and universities), and community-based providers contracted by or affiliated with designated LEAs. There are 29 public school districts in Orange County for grades K-12.

Beginning January 1, 2024, each Medi-Cal managed care plan (MCP) must reimburse providers of medically necessary outpatient mental health or substance use disorder treatment provided at a school site to a student 25 years of age or younger who is an enrollee of the plan, but only to the extent the MCP is financially responsible for those school site services under the MCP's contract with DHCS.

Welfare & Institutions Code section 5961.4 requires commercial health plans and the Medi-Cal delivery system, as applicable, to reimburse school-affiliated mental health providers at or above the DHCS-published CYBHI Fee Schedule rates for services furnished to students 25 years of age or younger, regardless of network provider status. Further, services provided as part of the CYBHI Fee Schedule are not subject to co-payment, coinsurance, deductible, or any other form of cost sharing. A provider's eligibility to provide services will be based on their scope of practice. The CYBHI Fee Schedule does not change any existing scope of practice requirements (*e.g.*, licensure/supervision requirements).

Discussion
As an MCP, CalOptima Health must provide access to outpatient non-specialty mental health services as a required benefit. The CYBHI Fee Schedule establishes the minimum rates at which CalOptima Health must reimburse LEAs and school-linked providers for providing the benefit to students under the age of

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26 at a school site, including on-campus, off-campus, and mobile clinic locations. The CYBHI Fee Schedule includes the appropriate billing codes, rates, and provider types for each service type billable as part of the CYBHI Fee Schedule program. The CYBHI Fee Schedule is pending approval by the Centers for Medicare and Medicaid Services and is subject to change. As of January 2024, the CalOptima Health Medi-Cal membership count for the age range 3-25 is approximately 355,000. CalOptima Health will initiate direct contracts with Orange County's 29 school districts to secure outpatient mental health services provided by school-linked providers. The agreement will be CalOptima Health's Medi-Cal Professional Services Contract template, with reimbursement terms in alignment with 100% of the CYBHI Fee Schedule developed by DHCS. Services covered by the contract include, neuropsychological testing and evaluation, psychological testing and evaluation, alcohol and substance abuse screening, psychotherapy for crisis, and psychiatric diagnostic evaluation. The contracts will be effective retroactive to January 1, 2024, and will not sunset so long as the benefit is in effect, pursuant to DHCS requirements.

Once contracted, the school districts can submit claims for reimbursement to CalOptima Health in compliance with Medi-Cal billing guidelines. The claims reimbursement will increase accessibility of school-linked behavioral health services to children and youth; the services will directly impact or enable student health outcomes. The CYBHI Fee Schedule includes a variety of outpatient, non-specialty mental health services; the services fall under the following categories: (1) Psychoeducation services, (2) screening and assessment services, (3) therapy services, and (4) case management. DHCS has approved a set of provider types (eligible practitioners) that will be allowed to seek reimbursement for school-linked behavioral health services:

Provider Types (eligible practitioners)

• Medical Doctors, including Psychiatrists (MD or DO)	• Pupil Personnel Services (PPS) Credentialed School Social Worker*	• Pupil Personnel Services (PPS Credentialed School Psychologist*	• PPS Credentialed School Counselor*
• Licensed Clinical Social Worker (LCSW)	• Licensed Marriage and Family Therapist (LMFT)	• Licensed Professional Clinical Counselor (LPCC)	• Licensed Psychologist
• Associate Marriage and Family Therapist (AMFT)	• Associate Social Worker (ASW)	• Associate Professional Clinical Counselor (APCC)	• Alcohol and Other Drug Counselor (AOD)
• Registered Nurses (RN), including Licensed Registered Nurses and Credentialed School Nurses	• Physician Assistant (PA)	• Nurse Practitioner (NP)	• Community Health Worker (CHW)
• Wellness Coaches**			

** PPS is pending State Plan Amendment approval*
***Wellness Coaches starting in 2025 is subject to State Plan Amendment approval*

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For every service included on the CYBHI Fee Schedule and provided to a student by a qualified practitioner, the school districts, or the affiliated school-linked providers, can submit a claim for reimbursement and receive 100% of the DHCS published CYBHI Fee Schedule rate. Under the CYBHI Fee Schedule, rendering practitioners must be either licensed (*e.g.*, LCSW, LPCC, Registered Nurse) or credentialed (*e.g.*, PPS credentialed school psychologist, PPS credentialed school counselor) to be eligible for reimbursement. Unlicensed practitioners (*e.g.*, CHW, ASW, AMFT) will need to be supervised, with a licensed provider filing the claim to receive reimbursement. Each service will be reimbursed at the same rate, regardless of the provider type rendering services.

Fiscal Impact

The recommended action is unbudgeted. The annual fiscal impact of Medi-Cal covered school mental health services is approximately $1.5 million. An appropriation of up to $750,000 from existing reserves will fund this action for the period of January 1, 2024, through June 30, 2024. Staff will monitor actual cost and utilization of these services and review data as it becomes available.

To the extent there is any additional fiscal impact, staff will request funding through separate Board actions. Management will include expenses associated with these services in the upcoming Fiscal Year 2024-25 Operating Budget.

Rationale for Recommendation

Approving the requested actions will support school aged CalOptima Health members' access to the required outpatient non-specialty mental health services benefit.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. DRAFT CYBHI Fee Schedule Scope of Services Rates and Codes

/s/ Michael Hunn *01/25/2024*
Authorized Signature **Date**

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Document updated as of 12/19/2023.
DRAFT – Pending CMS approval

CYBHI Statewide, Multi-Payer, School-Linked Fee Schedule Scope of Services, Codes, and Reimbursement Rates

This document outlines the scope of services for the Children and Youth Behavioral Health Initiative (CYBHI) statewide, multi-payer, school-linked fee schedule, which includes a variety of outpatient, non-specialty mental health services (e.g., psychoeducation, screening and assessments, therapy, case management). See below for the service categories, procedure codes, service descriptions, eligible practitioners, and reimbursement rates under the fee schedule.

The scope of services as outlined in this document is a draft, pending approval from the Centers for Medicare and Medicaid Services (CMS).

Service Category	Procedure Code	Service Description	Eligible Practitioners	Fee Schedule Rate
Psychoeducation services	96164	Health behavior intervention, Group; initial 30 minutes (only to be used if primary diagnosis is physical health condition)	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$8.77
	96165	Health behavior intervention, Group; each additional 15-minute (only to be used if primary diagnosis is physical health condition)	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$4.01
	96158	Health behavior intervention, individual; initial 30-min (only to be used if primary diagnosis is physical health condition)	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$58.34
	96159	Health behavior intervention, individual, each additional 15-min (only to be used if primary diagnosis is physical health condition)	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$20.11

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Service Category	Procedure Code	Service Description	Eligible Practitioners	Fee Schedule Rate
	H2027	Health behavior intervention (Psychoeducational service), Individual; each 15-minute (HA modifier req'd)	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$20.11
Psychoeducation services	H2027	Health behavior intervention (Psychoeducational service), Group; each 15-minute (HQ modifier req'd)	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS[i] School Counselor	$8.04
	99401	Preventive Medicine, Individual Counseling – 15 minutes	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$35.37
	99402	Preventive Medicine, Individual Counseling – 30 minutes	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$56.93
	99403	Preventive Medicine, Individual Counseling – 45 minutes	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$77.91
	99404	Preventive Medicine, Individual Counseling – 60 minutes	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$99.17
	99411	Preventive medicine counseling and/or risk factor reduction intervention(s); Group; 30 min	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$18.79
	99412	Preventive medicine counseling and/or risk factor reduction intervention(s); Group; 60 min	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$23.27
	H2014	Skills Training and Development (i.e., Patient Education); Individual; each 15-minute (HA modifier req'd)	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor, AOD Counselor	$20.11

Service Category	Procedure Code	Service Description	Eligible Practitioners	Fee Schedule Rate
	H2014	Skills Training and Development (i.e., Patient Education); Group; each 15-minute (HQ modifier req'd)	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor, AOD Counselor	$8.04
Psychoeducation services	98960	Education and training for patient self-management by a CHW: individual	Community Health Workers	$26.66
	98961	Education and training for patient self-management by a CHW: 2-4 patients	Community Health Workers	$12.66
	98962	Education and training for patient self-management a CHW: 5-8 patients	Community Health Workers	$9.46
	T1027	Family training and counseling for child development, per 15 minutes; U1 modifier req'd (for child enrolled in Medi-Cal OR their caregiver, regardless of Medi-Cal enrollment)	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$20.11
Screening & Assessment services	G0442	Screening for Annual Alcohol misuse, 15 min	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$17.14
	G9919	Screening for ACES/Trauma (High Risk)	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$29.00
	G9920	Screening for ACES/Trauma (Low Risk)	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$29.00
	G8431	Screening for depression is documented as being positive and a follow-up plan is documented	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$37.25
	G8510	Screening for depression is documented as negative, a follow-up plan is not required	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$17.14

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Service Category	Procedure Code	Service Description	Eligible Practitioners	Fee Schedule Rate
	99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services, 15-30 min	MD, PA, NP, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$31.24
Screening & Assessment services	99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services, 30 + min	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$59.61
	96156	Psychosocial Status Assessment	Psych, LCSW, LMFT, LPCC, ASW, AMFT, APCC, PPS School Psychologist, PPS School Social Worker	$85.40
	96130	Psychological Testing and Evaluation, first 60 min	MD, NP, PA, Psych, PPS Credentialed School Psychologists	$107.69
	96131	Psychological Testing and Evaluation, each additional 60 min	MD, NP, PA, Psych, PPS Credentialed School Psychologists	$77.94
	96132	Neuropsychological Testing and Evaluation, first 60 min	MD, NP, PA, Psych, PPS Credentialed School Psychologists	$116.97
	96133	Neuropsychological Testing and Evaluation, each additional 60 min	MD, NP, PA, Psych, PPS Credentialed School Psychologists	$89.46
	96136	Psychological or neuropsychological testing and scoring, first 60 min	MD, NP, PA, Psych, PPS Credentialed School Psychologists	$41.88
	96137	Psychological or neuropsychological testing and scoring, each additional 60 min	MD, NP, PA, Psych, PPS Credentialed School Psychologists	$39.01
	90791	Psychiatric Diagnostic Evaluation, 15 min	MD, NP, PA, Psych, LCSW, LMFT, LCPP, PPS Credentialed School Psychologists	$163.08
	96127	Developmental/Behavioral Screening and Testing (only to be used by non-mental health providers)	MD, NP, PA, RN	$4.81
	96116	Neurobehavioral Status Examination, first 60 min	MD, NP, PA, Psych, PPS Credentialed School Psychologists	$83.60
	96121	Neurobehavioral Status Examination, each additional 60 min	MD, NP, PA, Psych, PPS Credentialed School Psychologists	$70.17

Service Category	Procedure Code	Service Description	Eligible Practitioners	Fee Schedule Rate
	G2011	Alcohol and/or substance (other than tobacco) abuse structured assessment, 5- 14 min	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor, AOD Counselor	$14.81
Screening & Assessment services	G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment, 15- 30 min	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor, AOD Counselor	$31.24
	G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment, 30+ min	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor, AOD Counselor	$60.61
Therapy Services	90832	Psychotherapy session, individual, 16-37 min	MD, PA, NP, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$67.83
	90834	Psychotherapy session, individual, 38-52 min	MD, PA, NP, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$89.64
	90837	Psychotherapy session, individual, 53 or more min	MD, PA, NP, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$131.97
	90853	Psychotherapy session, group of 2-8 patients, 90 min or more	MD, PA, NP, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$23.96
	90839	Psychotherapy for Crisis, first 60 min	MD, PA, NP, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$126.55

Service Category	Procedure Code	Service Description	Eligible Practitioners	Fee Schedule Rate
	90840	Psychotherapy for Crisis, each additional 30 min	MD, PA, NP, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$62.46
	90847	Family psychotherapy session; single family with patient present, 50 min	MD, PA, NP, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$89.65
Therapy Services	90846	Family psychotherapy session; single family without patient present, 50 min	MD, PA, NP, Psych, Ed. Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker	$86.64
	90849	Family psychotherapy session; multiple families	MD, PA, NP, Psych, Ed. Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker	$33.88
Case Management	T1017	Targeted Case Management, 15 min	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor, AOD Counselor	$21.34
	99366	Case Management with patient or family present (Face to Face), 30 min	PA, NP, RN, Psych, Ed. Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$36.71
	99368	Case Management without Patient or Family present, 30 min	PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker, PPS School Counselor	$31.44
	H0034	Medication training and support, per 15 min	MD, PA, NP, RN, Psych, LCSW, LMFT, LPCC, AMFT, ASW, APCC, PPS School Psychologist, PPS School Social Worker	$22.94

APPENDIX

MD	Medical Doctors, including Psychiatrists
PA	Physician Assistants
NP	Nurse Practitioners
RN	Registered Nurses, including Licensed Registered Nurses and Credentialed School Nurses
Psych	Licensed Psychologist (including Educational Psychologists)
LCSW	Licensed Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LPCC	Licensed Professional Clinical Counselor
ASW	Associate Social Worker
AMFT	Associate Marriage and Family Therapist
APCC	Associate professional Clinical Counselor
PPS	Pupil Personnel Services Credentialed
AOD	Alcohol and Other Drug Counselors

CalOptima Health Board Action Agenda Referral

Action To Be Taken February 1, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

16. Approve the CalOptima Health Comprehensive Community Cancer Screening and Support Program Initiatives and Actions to Develop and Release a Notice of Funding Opportunity

Contacts

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

Recommended Actions

1. Approve the proposed CalOptima Health Comprehensive Community Cancer Screening and Support Program Initiatives:
    a. Community Grants
    b. Orange County Cancer Screening and Support Collaborative
    c. Vendor Contracts to Support the Member Journey
    d. Program Research and Evaluation
    e. Internal Program Support
2. Authorize CalOptima Health staff to develop and release a Comprehensive Community Cancer Screening and Support notice of funding opportunity (NOFO) to advance the goals of the program.
3. Authorize up to $15 million from the previously Board-allocated $50.1 million for the CalOptima Health Comprehensive Community Cancer Screening and Support Program to fund the first round of community grants.
4. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background and Discussion

In December 2022, the CalOptima Health Board approved the Comprehensive Community Cancer Screening and Support Program with a reallocation from Intergovernmental Transfer (IGT) 9 funds and an allocation from IGT 10 funds not to exceed $50.1 million, in aggregate, over five years. The goals of the program are to decrease late-stage cancer diagnosis rates, increase early detection through improved awareness and access to cancer screening, and improve quality and member experience during cancer screening and treatment among Medi-Cal members for breast, cervical, colon, and lung cancer (in certain smokers). In November 2023, the CalOptima Health Board approved the Comprehensive Cancer Screening Awareness and Education Campaign for $5.3 million over four years to develop and launch a multimedia, multilingual campaign that ensures a unified and clear message is spread across all residents of Orange County, including CalOptima Health members. The campaign discovery phase launched in January 2024 with internal and external stakeholder input planned throughout February.

As part of the overall program development, CalOptima Health sought input from community stakeholders such as the University of California, Irvine Chao Family Comprehensive Cancer Center, Orange County Cancer Coalition (comprised of 19 organizations), and the Coalition of Orange County Community Health Centers. Stakeholders shared many barriers faced in their efforts

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to improve cancer awareness, screening access, and member experience throughout cancer treatment. Barriers shared by these stakeholders include:

- Limited resources of small-scale organizations to develop member communication, educational materials, and awareness campaign toolkits.
- Need for patient navigators to guide members through cancer screening and support.
- Limited resources to support evening and weekend member appointments.
- Lack of equipment, technology, and automation to support timely and member focused outreach and interventions.
- Need to work with community organizations to build trust and support member linkage to appropriate screenings and services.

Proposed Program Initiatives

Based on stakeholder input, data analysis, and a review of research and best practices, CalOptima Health proposes the following initiatives with a cost totaling $44.7 million:

	Proposed Initiative	**Funding Type/ Amount**	**Description**
1	Community Grants *NOFO for Board approval included in this COBAR.*	Competitive Grant *Up to $30.0 million across two rounds*	Grants to support screening activities that may include costs for capacity building, infrastructure and capital improvements, and care coordination to increase screening and decrease late-stage discovery. Round 1: $15.0 million (release in February 2024, program year 2).
			Grants to build upon best practices and/or priorities emerging from the first round of grants. Round 2: $15.0 million (release date to be determined).
2	Orange County Cancer Screening and Support Collaborative	Direct Contracts *Up to $4 million*	Funds to support expansion of a member-centered cancer screening and support collaborative that brings together health systems, researchers, community-based organizations, and members to design and implement collaborative programs and strategies to decrease late-stage cancer discovery.*
3	Vendor Contracts to Support the Member Journey	Direct Contracts *Up to $5 million*	Direct vendor contract for Cancer Prevention Short Messaging Service Program inclusive of five cancer-focused use cases (breast, cervical, colorectal, lung, and general cancer). Additional vendor contracts to support member journey throughout screening, diagnosis, and cancer treatment (*e.g.*, care kits for newly diagnosed members, etc.).*
4	Program Research and Evaluation	Direct Contracts *Up to $5 million*	Direct contract with research and learning institution(s) to evaluate cancer incidence, treatment experiences, and genomic technologies to reduce disparities in late-stage cancer diagnoses.*
5	Internal Program Support	Program Operations *Up to $ 700,000*	Outreach and engagement activities (*e.g.*, community events, provider outreach/incentives, training for peer navigators/community health workers).

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** Staff will return to the Board for approval of contract(s).*

Notice of Funding Opportunity Grants

Based on input from key internal and external stakeholders, CalOptima Health staff request Board approval of $15.0 million dedicated to the release of the first NOFO for grants that support activities related to three funding categories:

1. Capacity building,
2. Infrastructure and capital improvements, and
3. Care coordination collaboratives.

Examples of funded grants may include, but not be limited to, the following programs or projects:

- Hiring staff, patient navigators or consultants with lived experience and/or expertise to expand and support member programs;
- Providing training and skills development to providers, community health workers, and other stakeholders;
- Implementing other strategies of increasing staff capacity to improve services and supports;
- Investment in technology and/or equipment that support improved systems, workflows, outreach, and access; and
- The creation and/or expansion of partnerships collaboration with other organizations and systems of care with expertise.

These grants are intended to improve services and supports for CalOptima Health members and at minimum result in the following expected outcomes:

1. Increased community and member cancer awareness and engagement;
2. Increased access and utilization of cancer screening services;
3. Decreased late-stage cancer discovery; and
4. Improved member experience throughout cancer treatment.

The NOFO will be released in two rounds of $15 million each to ensure the second round builds upon best practices and/or priorities emerging from the first round of grants. Round 1 will be released in February 2024. Staff anticipate that Round 2 will be released at a later date prior to the end of the program.

Grant Management and Oversight

Staff will develop and release the NOFO in accordance with CalOptima Health Policy AA.1400: Grant Management. Staff will return to the Board to request review and approval of recommended grantees. Specific milestones and reporting requirements and timelines will be developed as part of the grant award process.

Fiscal Impact

The recommended action is funded by a previous Board action on December 1, 2022, that authorized program funding from IGT 9 and 10 funds in an amount not to exceed $50.1 million to the Comprehensive Community Cancer Screening and Support Program. CalOptima Health

reserves the right to adjust or recoup funds for lack of demonstrating effort and performance against targeted measures.

Rationale for Recommendation

CalOptima Health is committed to improving cancer screening rates, health outcomes, and member experience. Approving the recommended actions will support improvement of cancer screenings, early cancer diagnosis, and treatment for CalOptima Health members. 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. Previous Board Action December 1, 2022, "Authorize Actions Related to the CalOptima Health Comprehensive Community Cancer Screening and Support Program for Medi-Cal Members."
2. CalOptima Health Policy AA.1400: Grant Management.
3. Notice of Funding Opportunity "Increasing early detection of cancer through improved awareness, access to screenings and quality of member experience throughout cancer treatment."

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 1, 2022	Authorize Actions Related to the CalOptima Health Comprehensive Community Cancer Screening and Support Program for Medi-Cal Members	5 Years	$50.1 million

/s/ Michael Hunn *01/25/2024*
Authorized Signature **Date**

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

Report Item

#. Authorize Actions Related to the CalOptima Health Comprehensive Community Cancer Screening and Support Program for Medi-Cal Members

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Katie Balderas, Director III, Population Health Management, (657) 235-6907

Recommended Actions

1. Approve the recommended expenditure plan for the CalOptima Health Comprehensive Community Cancer Screening and Support Program for Medi-Cal Members in an amount not to exceed $50.1 million; and
2. Authorize funding the program over the five-year period from:
    a. A reallocation of $19,134,815 from Intergovernmental Transfer (IGT) 9 funds previously allocated for the Whole Child Model (WCM) program and the 24/7 Virtual Urgent Care Services After Hours Initiative; and
    b. An allocation of the remaining IGT 10 funds, estimated at $31.0 million.

Background & Discussion

CalOptima Health strives to be the healthcare exemplar for all Orange County (OC) residents. The goal is for all of Orange County to have the lowest in the nation late-stage cancer incidence rate for breast, cervical, colon, and lung cancer in certain smokers. In other words:

- With rare exception, no one should die from breast cancer.
- With rare exception, no one should die from cancer of the cervix.
- With rare exception, no one should die from cancer of the colon.
- With rare exception, no one should die from lung cancer in certain heavy smokers.

CalOptima Health seeks to create a new OC health ethos with respect to cancer care by going after these four specific cancers that are relatively easy to detect compared to many more occult cancers. Early detection of these specific cancers has an incredible return on investment. CalOptima intends to build this new ethos by leveraging the key cancer centers and community opinion makers to the point where cancer detection for these specific cancers is part of the community's daily discussions. Additionally, having the lowest late-stage cancer detection in the nation will be a source of intense community pride.

CalOptima Health proposes a five year, approximately $50.1 million Comprehensive Community Cancer Screening and Support Program. The program will increase early detection through improved awareness and access to cancer screening, decrease late-stage cancer diagnoses rates and mortality, and improve quality and member experience during cancer screening and treatment procedures among Medi-Cal members.

The proposed Comprehensive Community Cancer Screening and Support Program will create a culture of cancer prevention, early detection and collaboration with partners towards a shared goal of dramatically decreasing late-stage cancer incidence and ensuring that all Medi-Cal members have equitable access to high quality care. The Program will use a phased-in approach to invest approximately $10 million per year over the next five years toward the following three pillars:

1) Increasing community and member awareness and engagement;

2) Increasing access to cancer screening; and
3) Improving member experience throughout cancer treatment.

As of November 14, 2022, 3,925 CalOptima Health members were newly diagnosed with cancer. Of these cases, 480 are lung cancer, 565 are breast cancer, 120 are cervical cancer, and 477 are colorectal cancer. The COVID-19 pandemic has significantly disrupted preventive care and cancer screenings, leading to a decrease in early detection and treatment[1]. Between 2019 and 2021, Medi-Cal Healthcare Effectiveness Data and Information Set (HEDIS) rates decreased by approximately 5% for breast and cervical cancer screenings. Currently, more than one-third of eligible members have not received their cervical, breast, or colorectal cancer screenings.

Increasing these cancer screening rates is crucial for the early diagnosis and treatment of cancer, ultimately increasing life expectancy, quality of life, and reducing healthcare costs. For example, the five-year survival rate for colorectal cancer that has spread is only 15 percent, compared to a 90 percent survival rate when detected earlier at a localized stage. Yet every year in Orange County, an average of 1,500 community members are diagnosed with late-stage cancer of the breast, cervix, or colon[2]. Additionally, trends in late-stage colorectal cancer diagnoses significantly increased over the most recent ten-year period in Orange County, and in 2022, colorectal cancer will likely continue to be the second leading cause of cancer-related deaths following lung cancer[1].

Staff plan to collaborate with the Orange County Cancer Coalition, providers, health networks, and community-based organizations to ensure that funds are utilized equitably to address disparities and build sustained capacity in the cancer screening and treatment community infrastructure.

Recommended Funding Source

Staff recommends reallocation of unused IGT 9 funds and allocation of the remaining IGT 10 funds in order to support this program over a five-year period. Specifically, there is $19,134,815 available in two initiatives previously approved by the Board on April 2, 2020 (see table below). After finalizing the state funding and risk corridor settlement for the WCM program with our health networks, the actual need for IGT 9 funds for this purpose was lower than originally anticipated. Additionally, after conducting user research, management directed staff to end the 24/7 Virtual Urgent Care Services After Hours Initiative due to competing priorities and limited value to CalOptima Health members at this time.

CalOptima Health's share of IGT 10 funds is $67.82 million, of which $45.15 million was received in May 2021, $18.42 million was received in December 2021 and $4.25 million was received in March 2022. As of February 3, 2022, the Board has allocated $36.90 million of IGT 10 funds, leaving approximately $30.92 million unallocated. More information on IGT 10 is attached. The total program funding requested from IGT funds over five (5) years is approximately $50.1 million.

IGT	Amount
IGT 9: Proposed Reallocation	
• Whole Child Model	$17,134,815
• 24/7 Virtual Urgent Care Services After Hours Initiative	$2,000,000

[1] https://www.science.org/doi/10.1126/science.abd3377
[2] https://statecancerprofiles.cancer.gov/index.html

Subtotal	$19,134,815
IGT 10: Proposed Allocation	$30,916,053
Total	**$50,050,868**

Staff will return with additional recommended actions and a more detailed implementation plan for Board review and approval at a future meeting.

Fiscal Impact

The recommended action to authorize reallocation of $19,134,815 in IGT 9 funds and allocation of the remaining IGT 10 funds, estimated at $31.0 million does not have a net fiscal impact to CalOptima Health's total net assets since the IGT revenue has been or will be recognized in the fiscal year the funds are received.

Rationale for Recommendation

CalOptima Health is committed to improving cancer screening rates and health outcomes for members. The recommended action will improve access to cancer screenings, early cancer diagnosis, and treatment for CalOptima health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Previous Board Action February 3, 2022, "Authorize Allocation of Intergovernmental Transfer (IGT) 10 Funds to the Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP)
2. Intergovernmental Transfers (IGT) 10 Summary

_____ _____

Authorized Signature **Date**

Policy:	AA.1400
Title:	**Grant Management**
Department:	Strategic Development
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 05/04/2023*
Effective Date:	05/04/2023
Revised Date:	Not Applicable
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines the criteria and expectations to ensure consistency and accountability in managing discretionary Grant funding disbursed by CalOptima Health.

II. POLICY

A. Approach

1. When resources permit, CalOptima Health may designate authorized funds specifically for CalOptima Health Board of Directors (hereinafter, 'Board')-approved Grants to eligible external organizations with the goal of improving the health of CalOptima Health's Members.

2. CalOptima Health shall ensure the distribution of Grant funds is reflective of CalOptima Health's mission, consistent with CalOptima Health's Strategic Plan, any Board-approved fund allocation plan, and/or any funding source legal parameters and funding restrictions. CalOptima Health shall uphold the following tenets when awarding Grants:

   a. CalOptima Health shall consider Proposals from external organizations that provide services for programs or projects aligned with CalOptima Health's mission, Strategic Plan, and/or any Board-approved fund allocation plan and directly serve CalOptima Health Members.

   b. Each Grant application shall receive a thorough, unbiased evaluation and review including an assessment of organizational experience, capacity, fiscal soundness, alignment with CalOptima Health's mission, Strategic Plan, and/or Board-approved fund allocation plan, demonstrated need, benefit to CalOptima Health Members, and feasibility.

   c. CalOptima Health shall strive for timely application approval and payment of award and shall regularly evaluate the application process to identify areas for greater efficiency.

   d. Reporting requirements for Grant awards shall align with section III.B. of this policy and shall be commensurate with the amount of funds being awarded and with the nature of the funding opportunity.

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III. PROCEDURE

A. Pre-Award Assessment:

1. Grant objectives shall be in alignment with organizational strategic priorities.

2. Grant outcomes shall improve or address critical needs of CalOptima Health Members.

B. Award Grant: Establishing Goals and Metrics

1. CalOptima Health will work with Grantees to ensure that all Grants have established one or more goals that direct the use of Grant funds.

2. CalOptima Health will work with all Grantees to ensure that Grants align with one or more metrics signifying the successful accomplishment of its goal or goals. These metrics will be the basis for monitoring and reporting outcomes and successes.

C. Post-Award: Grant Monitoring and Reporting Requirements

1. CalOptima Health Operations department and/or other internal subject matter experts shall monitor a Grantee's compliance and progress towards achieving the goals presented in the Grantee's Proposal by reviewing the Grant Progress Reports.

    a. Unless otherwise specified in the Grant contract, Grantees shall submit semi-annual Grant Progress Reports, detailing Grant activities, along with any required supporting materials.

        i. The format and specific details of the Grant Progress Report shall be mutually agreed upon by CalOptima Health and the Grantee.

    b. The semi-annual Grant Progress Reports may require a breakdown of funding utilization by category as mutually agreed upon by CalOptima Health and the Grantee.

2. CalOptima Health may also utilize Grant Progress Reports to provide updates to CalOptima Health's executives and the CalOptima Health Board about its Grant funding activities.

3. Grantees shall also submit a final closeout report as stipulated in the Grant contract, summarizing the actions taken by the Grantee over the course of the entire Grant contract term.

    a. The final closeout report will include a breakdown by category of the funds used, and a reconciliation to indicate all funds were used according to the intended purpose.

4. As part of CalOptima Health's due diligence, CalOptima Health's designated representative(s) may also elect to conduct site visits to a Grantee's business premises and/or site(s) of Grant-funded service delivery during the Grant contract term for the following actions including, but not limited to:

    a. Meet the Grantee's senior leadership, as well as the Grantee's staff or volunteers with primary responsibility for conducting the funded activities;

    b. Engage in dialogue with the Grantee about progress toward project milestones and objectives, notable successes, implementation challenges, and early lessons learned;

c. Learn of any anticipated requests for scope or budget changes, or no-cost extensions; and

d. See program services/activities first-hand, if applicable and feasible.

5. Grant payments may be delayed or withheld if site visits and/or Grant Progress Reports reveal Grantees are not making sufficient progress towards stated goals or are not meeting other Grant contract requirements.

   a. If sufficient progress is not being made toward Grant contract goals and metrics, CalOptima Health will work with Grantees to understand why metrics were not achieved and work with the Grantee to realign metrics if deemed appropriate.

6. CalOptima Health may conduct audits of the Grantee and/or of the related CalOptima Health operational areas and financial data during the course of the Grant and/or at the conclusion of the Grant.

   a. The audits will be conducted to confirm reported expenditures, performance measures, compliance with key Grant requirements, and other relevant factors as applicable to the specific Grant.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Strategic Plan

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/04/2023	AA.1400	Grant Management	Administrative

IX. GLOSSARY

Term	Definition
Grantee	A recipient of a grant.
Grants	A financial award given by CalOptima Health to an eligible recipient to achieve a particular purpose or project. Grants are generally not expected to be repaid by the recipient when appropriately used for an approved grant project.
Member	A beneficiary enrolled in a CalOptima Health program.
Proposal	An application submitted to CalOptima Health used to formally request funding for a specific project.
Strategic Plan	CalOptima Health's strategic priorities, objectives, and action plans.

CalOptima Health Comprehensive Community Cancer Screening and Support Program Notice of Funding Opportunity

Increasing early detection of cancer through improved awareness, access to screenings and quality of member experience throughout cancer treatment.

CalOptima Health solicits grant applications to increase early detection and reduce late-stage cancer diagnoses among CalOptima Health members.

Application Deadline — March 29, 2024 (5 p.m. PST)

Background

CalOptima Health's mission is to serve members' health with excellence and dignity, respecting the value and needs of each person. To remove barriers to optimal cancer care and improve member health outcomes, CalOptima Health is committed to decreasing late-stage cancer discoveries by focusing on increasing member and community awareness, education, and access to cancer screenings, and improving member experience and support throughout cancer treatment.

CalOptima Health sought input from key community stakeholders to inform the design of the Comprehensive Community Cancer Screening and Support funding opportunity. Stakeholders shared barriers faced in their efforts to improve cancer awareness, screening access, and member experience throughout cancer treatment. These barriers include:

- Limited resources among smaller organizations to develop member communication, educational materials, and awareness campaign toolkits
- Lack of patient navigators to guide members through cancer screening and support
- Limited resources to support evening and weekend member appointments
- Lack of equipment, technology and automation to support timely and member focused outreach and interventions

- Need for community organizations to build trust and support member linkage to appropriate screenings and services

To address these barriers, CalOptima Health will provide two rounds of funding. The first round will be for a two-year grant cycle providing up to $15 million in total grant funding to increase early detection and reduce late-stage diagnoses of breast, cervical, colorectal and lung cancer among CalOptima Health members. A second round of funding will be launched at a later date (to be determined) and will build upon best practices and/or priorities emerging from the first round of grants. This first funding opportunity will be open for applications February 9 – March 29, 2024.

Description of Funding Categories

Applicants must demonstrate how their funding request will increase awareness and access to cancer screening, decrease late-stage cancer diagnosis rates, and/or improve quality and member experience during cancer screening and treatment. Priority for this grant funding opportunity will be given to projects focused on addressing health inequities for populations highly impacted by breast, cervical, colorectal and/or lung cancer in the following grant categories:

1. Capacity Building

This grant category is intended to support medical providers and organizations with capacity building to expand services and support for CalOptima Health members. Eligible proposed projects may include:

- Hiring staff, patient navigators or consultants with lived experience and/or expertise to expand and support member programs
- Providing training and skills development
- Implementing other strategies of increasing staff capacity to improve services and support

2. Infrastructure and Capital Improvements

This grant category is intended for infrastructure and capital investments. Eligible proposed projects may include:

- Investment in technology and/or equipment that support improved systems, workflows, outreach and access

3. Care Coordination Collaboratives

The care coordination and collaborative category is intended for investments that drive collaborative innovations across systems of care. Eligible projects may include:

- Creation and/or expansion of partnerships or collaboration with other organizations and systems of care

Grant Amounts and Duration

Total grant funding available for this round of funding is $15 million for a two-year grant cycle.

Awarded funds must be used to improve Medi-Cal covered services and support for CalOptima Health members with a focus on cancer prevention and education, early detection, treatment, and support.

For awarded grants, payments will be made in two installments. The first payment shall be made upon execution of a grant agreement, with subsequent payments made at the end of each project year contingent upon CalOptima Health's receipt and approval of Quarterly Progress Reports, Annual Progress Reports and/or Final Report which are due as condition of payment.

Entities Eligible to Apply

CalOptima Health will consider applications from nonprofit and for-profit organizations, joint ventures, or partnerships that serve the identified purpose of this Notice of Funding Opportunity (NOFO).

Applicants may submit proposals for one or more categories.

Applicants that previously received funding from CalOptima Health must be in good standing with the terms of their contract or grant agreement to be eligible for new funding.

Proposed Project Requirements

Population

This funding opportunity must be used for CalOptima Health Medi-Cal Members.

Grant Objectives

Applicants must propose projects or programs that align with one or more of the funding priorities described above and support at least one of the following Comprehensive Community Cancer Screening and Support Program pillars:

1. Increase community and member awareness and engagement
2. Increase access to cancer screening
3. Improve member experience throughout cancer treatment

Applicants must clearly define grant objectives and submit a project plan that clearly outlines how expected outcome will be measured.

Reporting Requirements

CalOptima Health monitors and evaluates grant progress reports to appraise grant objectives. Grantees are required to submit semi-annual progress reports in addition to a final report at the end of the grant term. Successful completion of reports is a condition for funding disbursement.

CalOptima Health will require grantees to track key performance indicators in the semi-annual report, examples of which may include (but not be limited to):

- Total number of CalOptima Health members currently served by the applicant
- Total additional CalOptima Health Members served through the grant
- Total number of CalOptima Health members referred to screening and outcome of referral (e.g., successfully completed screening, declined screening, required additional examination prior to screening)

Evaluation Criteria

Complete applications will be evaluated using the following evaluation criteria:

	Criterion	Maximum Points	Description of Basis for Assigning Points
1	Alignment with program	Pass/Fail	• Project aligns with the program goals to increase awareness and access to cancer screening, decrease late-stage cancer diagnosis, and/or improve quality and member experience during cancer screening and treatment procedures.
2	CalOptima Health core mission and value alignment	20	• Project improves member health outcomes by addressing health disparities, removing barriers to access and providing opportunities for more CalOptima Health members to be treated with excellence and dignity.
3	Decreases late-stage cancer diagnosis	20	• Project demonstrates ability to decrease late–stage cancer diagnosis.
4	Equity	20	• Applicant describes how they will identify and support populations most impacted by cancer, and how they will tailor grant activities to meet the needs of the focus population
5	Project Implementation	20	• Project plan is complete, incorporates evidence-based practices and includes specific objectives, logical and feasible activities, as well as clearly defined measures of success.

6	Budget and Financial Management	10	• Project budget is sound and provides detail on program plan. • Able to demonstrate strong financial management capacity.
7	Capacity and Project Readiness	10	• Applicant demonstrates experience in developing programs and interventions for Medi-Cal populations in Orange County. • Projects can be launched soon after the grant award.
Total Earnable Points		100	

Application Steps

All documents related to this Notice of Funding Opportunity and access to the application portal will be made available via this link: [add link to Website]

Application portal will be opened from February 9 - March 29, 2024.

Timeline*

Date	Activity
February 9, 2024	NOFO Released and Application Portal Opens
February 13, 2024	Q&A Session (virtual)
February 19, 2024	Questions Posted from Bidder's Conference
March 29, 2024	Application Deadline (application portal will close at 5 p.m.)
April 1 – April 12, 2024	Internal Review and Selection
May 2, 2024	Grantee Approval by CalOptima Health Board of Directors
May 3 – 31, 2024	Grant Agreements Processed
June 1, 2024	Grant Implementation Starts

*Dates subject to change.

Q&A Session

Join the Q&A Session for this funding opportunity by registering below:

Date and Time: Tuesday, February 13, 2024, 2 p.m.
Link: https://us06web.zoom.us/webinar/register/WN_uTcGDaOrQTOkg5CoeFm6DQ

Point of Contact

For questions about the funding opportunity or application, contact Population Health Management at populationhealthmanagement@caloptima.org.

CalOptima Health Board Action Agenda Referral

Action To Be Taken February 1, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
17. Approve Actions Related to Homelessness Prevention and Stabilization Pilot Program

Contacts
Kelly Bruno Nelson, Executive Director, Medi-Cal/CalAIM, (657) 550-4741
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Action
Authorize planning and coordination of California Advancing and Innovating Medi-Cal (CalAIM) services for CalOptima Health members who enroll in the County of Orange (County) Homelessness Prevention and Stabilization Pilot Program (Program).

Background
On January 9, 2024, the County Board of Supervisors unanimously approved the new Program, introduced by Supervisor (and CalOptima Health Board Member) Vicente Sarmiento, which will combine homelessness prevention and robust case management aimed at promoting housing stability. Funded by a $3 million aggregate allocation from the County, the Program will provide short-term (no longer than 12-months) financial intervention to individuals and families at risk of homelessness or experiencing a housing crisis to pay rental arrears, past due utility bills (electricity, gas, water, and trash), and forward rent and/or utility bills based on financial need.

The County will issue a request for proposals to select a nonprofit to administer the Program and determine eligibility based on area median income and risk of eviction. The total direct financial assistance to be provided by the Program per household is $10,800, with a maximum one-time assistance of $6,000 for rental arrears and past due utility bills, and $400 maximum per month for forward rent and/or utility bills. At the same time, the County program proposes robust case management that will focus on developing financial stability plans and supportive services plan to identify community-based programs and resources that support the household in achieving long-term housing stability.

On January 1, 2022, CalOptima Health launched two of the initial components of the five-year CalAIM initiative through the Department of Health Care Services to improve the quality of life and health outcomes of the Medi-Cal population by meeting people where they are in life, addressing social drivers of health, and breaking down barriers in accessing care. These two components are enhanced care management (ECM) and community supports.

Discussion
Under CalAIM, CalOptima Health members who enroll in the County's new Program may also be eligible for ECM through which members may receive comprehensive case management from a single lead care manager who coordinates all their health and related care, including physical, mental, and dental care as well as social services. ECM makes it easier for members to get the right care at the right time in the right setting as well as receive comprehensive care that goes beyond the doctor's office or hospital.

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Additionally, Program participants may also be eligible for one or more community support services related to homelessness prevention and housing stabilization, including housing transition navigation services, housing deposits, and housing tenancy and sustaining services. This latter service aims to help members stay safe and stable in a home and may include education on the rights and responsibilities of the tenant and landlord, as well as ongoing support with activities related to household management.

Given the strong correlation between community supports and the services provided by the County's Program, CalOptima Health staff have begun to work with County staff to coordinate services, prevent duplication and maximize outcomes. As such, staff requests authority to continue planning and coordinating ECM, community supports and other related services for CalOptima Health members who may also be participating in the County's Program.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Supporting and coordinating implementation of the County's Program will help ensure that CalOptima Health members receive all eligible housing-related services in order to promote long-term housing stability and improve whole person care.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

/s/ Michael Hunn *01/25/2024*
Authorized Signature **Date**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken February 1, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
18. Authorize Actions Related to Public Housing Authorities in Orange County

Contacts
Kelly Bruno Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Action
Authorize the Chief Executive Officer to enter into a Memorandum of Understanding (MOU) with the four Public Housing Authorities (PHAs) in Orange County to create a referral framework for California Advancing and Innovating Medi-Cal (CalAIM) supportive services for CalOptima Health members receiving or eligible to receive a housing voucher.

Background
In January 2022, the Department of Health Care Services (DHCS) launched the CalAIM initiative. CalOptima Health participates in CalAIM, which seeks to improve quality of life and health outcomes of the Medi-Cal population by leveraging Medi-Cal as a tool to address many complex challenges facing California's most vulnerable residents, including those facing housing insecurity and instability. Two specific initiatives within CalAIM are Enhanced Care Management (ECM) and Community Supports. CalOptima Health offers all 14 Community Supports, which are directed at supporting some of the most vulnerable populations in Orange County, including those at risk of or experiencing homelessness.

There are four PHAs in Orange County: the Orange County PHA, Anaheim PHA, Garden Grove PHA, and Santa Ana PHA. These local PHAs, among other things, administer federally funded programs to provide rental assistance to qualified tenants in publicly and privately owned rental housing. The PHAs administer the Housing Choice Voucher (HCV) program, as well as Special Purpose Voucher (SPV) programs such as the Emergency Housing Voucher program, Stability Voucher program, Mainstream Voucher program, Veterans Affairs Supportive Housing, Non-Elderly Disabled program, Family Unification program, and Foster Youth to Independence program. Participants in the HCV and SPV programs may use rental assistance in a variety of rental dwellings with property owners willing to participate in the program.

Discussion
The MOU establishes a referral framework with the four local PHAs to CalOptima Health for HCV and SPV program participants and applicants to be referred by the PHAs to CalOptima Health for CalAIM ECM and Community Support services. Further, the MOU affirms the roles and responsibilities of the four PHAs and CalOptima Health regarding the referral relationship and provides the framework for the referral program and sharing of information. The MOU provides for the disclosure of information to CalOptima Health from all four PHAs. *See,* Attachment 2. The information shared will include the minimum necessary to confirm enrollment of a PHA program participant in CalOptima Health's Medi-Cal program. CalOptima Health staff will then either confirm Medi-Cal enrollment or refer the individual to the Orange County Social Services Agency for potential Medi-Cal enrollment. For already enrolled

Medi-Cal members, CalOptima Health staff will contact PHA program participants and applicants to determine eligibility for CalAIM ECM and Community Supports. CalOptima Health staff will provide aggregate data to the PHAs.

Each party to the MOU will communicate with participants and applicants in accordance with applicable government agency requirements, policies, and procedures. The PHAs and CalOptima Health staff will meet as needed to review services described in the MOU. Together, the PHAs and CalOptima Health will work to ensure that individuals and household members who are referred under the MOU are given the opportunity for appropriate follow-up. Any party to the MOU may terminate its participation with or without cause by providing thirty (30) days' written notice to the other parties prior to the effective date of termination.

The City Councils for Anaheim PHA, Garden Grove PHA, and Santa Ana PHA have all approved entering into the MOU. The Orange County PHA is slated to go to their Board on February 27, 2024, for approval.

Fiscal Impact

The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2023-24 Operating Budget.

Rationale for Recommendation

CalOptima Health and the PHAs share common goals of improving health and housing outcomes for residents of Orange County, including individuals experiencing or at risk of homelessness. The partnership with the PHAs as described in the MOU will ensure that PHA program participants and applicants have a path for Medi-Cal enrollment and CalAIM ECM and Community Support services enrollment.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Memorandum of Understanding
2. CalAIM Housing and Health Services Voluntary Consent Form to Release, Share, and Disclose Confidential Information
3. Entities Covered by this Recommended Board Action

/s/ Michael Hunn *01/25/2024*
Authorized Signature **Date**

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MEMORANDUM OF UNDERSTANDING

between

ORANGE COUNTY HOUSING AUTHORITY, a public housing authority established under California Health & Safety Code section 34200 and operationally organized under the Orange County Community Resources Department, **ANAHEIM HOUSING AUTHORITY**, **GARDEN GROVE HOUSING AUTHORITY**, **SANTA ANA HOUSING AUTHORITY**

and

ORANGE COUNTY HEALTH AUTHORITY dba CALOPTIMA HEALTH

This Memorandum of Understanding ("MOU") is entered into by and between the Orange County Health Authority, a public agency doing business as CalOptima Health ("CalOptima"), Orange County Housing Authority, Anaheim Housing Authority, Garden Grove Housing Authority, and Santa Ana Housing Authority (each public housing authority is individually referred to as "PHA" and collectively "PHAs"). Each PHA and CalOptima may each be referred to individually as a "Party" and collectively as the "Parties".

I. BACKGROUND

CalOptima is a public agency that provides health care coverage for Orange County residents who are eligible for Medi-Cal. In January 2022, the Department of Health Care Services ("DHCS") launched the California Advancing and Innovating Medi-Cal ("CalAIM") initiative. CalOptima participates in CalAIM, which seeks to improve quality of life and health outcomes of the Medi-Cal population by leveraging Medi-Cal as a tool to address many complex challenges facing California's most vulnerable residents, including those facing housing insecurity and instability. Two specific initiatives within CalAIM are Enhanced Care Management ("ECM") and Community Supports. CalOptima has committed to offering all 14 Community Supports and expanding its provider network accordingly. These Community Supports services are directed at supporting some of the most vulnerable populations in Orange County, including those experiencing homelessness, older adults, children with complex care needs, and those involved with the justice system.

As local public housing authorities, each PHA, among other things, administers federally funded programs to provide rental assistance to qualified tenants in privately owned rental housing. Each PHA administers the Housing Choice Voucher ("HCV") program, as well as Special Purpose Voucher ("SPV") programs such as the Emergency Housing Voucher program, Stability Voucher program, Mainstream Voucher program, Veterans Affairs Supportive Housing, Non-Elderly Disabled program, Family Unification program, and Foster Youth to Independence program. Participants and applicants in the HCV program and SPV programs may use rental assistance in a variety of rental dwellings with property owners willing to participate in the program. Each PHA desires to help connect certain participants and applicants to support services offered by CalOptima pursuant to a duly executed written consent form with its participants and applicants.

II. PURPOSE

This MOU establishes a referral framework from each PHA to CalOptima for HCV and SPV program participants and applicants to leverage the ECM and Community Support services provided through CalAIM. This MOU affirms the PHAs' and CalOptima's roles and responsibilities regarding the referral relationships and provides the framework for each PHA's referral program and sharing of information. This MOU provides for, among other things, the disclosure of information to CalOptima, in accordance with the CalAIM Housing and Health Services Voluntary Consent Form to Release, Share, and Disclose Confidential Information, attached as Exhibit A to this MOU. The information will include the minimum necessary to confirm the enrollment of a PHA program participant or applicant in CalOptima's Medi-Cal program. This information may include, for example, full name, date of birth, and social security number.

III. TERM

This MOU becomes effective upon the last date the Parties execute this MOU on the signature page ("Effective Date") and remains in effect until terminated under Section XI.

IV. POPULATION TO BE SERVED

This MOU applies to any household member(s) who holds or is applying to hold a HCV or SPV issued by a PHA and are voluntarily interested in, or already enrolled in, CalOptima's Medi-Cal program and consent to provide their information to CalOptima by executing the "CalAIM Housing and Health Services Voluntary Consent Form to Release, Share, and Disclose Confidential Information."

This may include:

- HCV or SPV applicants who have an active application in process of eligibility that has been pulled off of a waiting list for an HCV or SPV;
- HCV or SPV applicants who are waiting to be pulled off of a waiting list so long as they provide their written consent;
- HCV or SPV participants in the Project-Based Voucher program; or
- Any other category of HCV or SPV applicant or participant not already listed who may be served by a PHA.

V. SCOPE OF CALOPTIMA SERVICES

A. Once CalOptima receives information from a PHA of: (i) an individual or family (household) member with an HCV or SPV (or who is waiting to receive their HCV or SPV); and (ii) who has provided written consent to share their information with CalOptima, by executing the CalAIM Housing and Health Services Voluntary Consent Form to Release, Share, and Disclose Confidential Information attached as Exhibit A, CalOptima shall follow this process:

1. If the individual or household member is unsure of their Medi-Cal status, CalOptima shall either:

a. Confirm Medi-Cal enrollment; or

b. If the individual or household member is not enrolled in Medi-Cal, refer the individual or household member to the Orange County Social Services Agency ("SSA") for potential Medi-Cal enrollment.

2. Pursuant to an already existing enrollment. CalOptima staff shall make reasonable efforts to contact all such enrollees to assess for eligibility for ECM and Community Supports services. If eligible, and interested, CalOptima will make appropriate referrals for services. CalOptima shall make reasonable efforts to monitor ECM and Community Supports services provided to individuals or household members to ensure they are beneficial.

B. CalOptima shall provide aggregate data to each PHA regarding Medi-Cal eligibility and service delivery referrals under this MOU.

C. CalOptima will contract with CalAIM providers to provide Community Support and ECM services, as required under CalAIM. In addition to ECM services, those Community Support services include, but are not limited to (as further described and defined under CalAIM):

1. Housing transition navigation services;

2. Housing deposits;

3. Housing tenancy and sustaining services;

4. Short-term post-hospitalization housing;

5. Recuperative care;

6. Respite services;

7. Day habilitation services;

8. Asthma remediation;

9. Medically tailored meals/medically-supportive food;

10. Community transition services/nursing facility transition to a home;

11. Personal care and homemaker services;

12. Environmental accessibility adaptations (home modifications); and

13. Nursing facility transition/diversion to assisted living facilities, such as Residential Care facilities for elderly and adult residential facilities.

D. CalOptima shall provide oversight and monitoring of its contracted CalAIM providers and manage all CalAIM providers that perform services under this MOU.

VI. SCOPE OF SERVICES TO BE PROVIDED BY EACH PHA

A. From among its population of HCV and SPV program participants and applicants, each PHA will:

1. Request the voluntary written interest and consent of the program applicant or participant to register for Medi-Cal or their current enrollment status in Medi-Cal in order to gain access to the benefits available to the applicant or participant through CalAIM. Each PHA may make its request for voluntary written interest and consent, at any time, for an HCV or SPV holder.

2. Request written consent to disclose applicant or participant information, or other related information, to CalOptima so that the applicant or participant may access CalAIM benefits. Each PHA shall use reasonable efforts to make this request at least once in writing during the eligibility process for issuance of an HCV or SPV.

3. Request written voluntary interest and consent from participants and applicants to release information to CalOptima, including to the CalAIM providers contracted by CalOptima, as provided in Exhibit A.

B. For those HCV and SPV recipients who voluntary provide written interest and consent under Section IV.A (Population To Be Served) in order to disclose their information to CalOptima for CalAIM purposes, each PHA will:

1. Share the minimum information necessary to confirm the program applicant or participant's enrollment in CalOptima's Medi-Cal program. This information may be shared electronically in a secure system, via transfer of a physical form signed by the applicant or participant, or via another method agreed upon by the Parties that complies with applicable laws.

C. Pursuant to the HCV and SPV program regulations found at 24 CFR Parts 5 and 982, each PHA will:

1. Issue vouchers for participants to search for appropriate rental housing (if a voucher has not already been issued).

2. Administer and provide the participant with monthly rental assistance in accordance with the regulations in 24 CFR Part 982 by providing housing assistance payments on behalf of the participant to the applicable landlord.

VII. COMMUNICATION

During the term of this MOU, each PHA and CalOptima will remain in contact as necessary to effectuate the purpose of this MOU. Each Party will communicate with its mutual participants and applicants in accordance with applicable government agency requirements, policies and procedures. Each PHA and CalOptima will meet as needed to review services described in this MOU. Primary point of contacts will be assigned by each PHA and CalOptima. CalOptima's point of contact will be within the CalAIM team.

VIII. COLLABORATION

Each PHA and CalOptima will work together to ensure that individuals and household members who receive services under this MOU are given the opportunity to be referred to CalOptima for appropriate follow-up if they are interested in or are already enrolled in Medi-Cal. Each PHA and CalOptima shall use reasonable efforts to ensure that the disclosure of participant and applicant information from a PHA to CalOptima is performed pursuant to an executed CalAIM Housing and Health Services Voluntary Consent Form to Release, Share, and Disclose Confidential Information, as provided in Exhibit A. CalOptima shall implement procedures to ensure that it only accepts participant and applicant information from a PHA for participants and applicants who have provided written consent to share their information with CalOptima, by executing the CalAIM Housing and Health Services Voluntary Consent Form to Release, Share, and Disclose Confidential Information attached as Exhibit A. Each Party agrees to meet as needed to address the following:

A. Funding opportunities;

B. Federal regulations, agency policies and compliance;

C. Program operations, procedures, and logistics; and

D. Participant/applicant needs and challenges.

IX. RECORDS RETENTION

Each PHA and CalOptima will retain all records related to this MOU for at least three (3) years from the date of inactivity of services or for such longer periods as required by law.

X. CONFIDENTIALITY

A. Each PHA and CalOptima agree to maintain the confidentiality, privacy, and security of all applicant, participant, and tenant records and information pursuant to all applicable federal and state laws and regulations, including without limitation, U.S. Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including interpretive case law, as may now exist or be hereafter amended, to the extent applicable. For the sake of clarity, none of the PHAs are covered entities, as that term is defined and used under the HIPAA and its implementing regulations, and none of the PHAs are CalOptima's business associate, as that term is used in HIPAA and its implementing regulations. All information that a PHA discloses under this MOU shall be considered and kept

confidential by CalOptima, CalOptima's contracted Medi-Cal providers, and Cal-Optima's employees, agents, staff, and volunteers.

B. Parties further agree that any breach of confidentiality or privacy concerning any applicant, participant, and/or tenant records related to this MOU shall be addressed pursuant to applicable law and each Party's internal compliance program, as amended from time to time.

C. The Parties shall require all staff, agents, employees, volunteers, vendors, contractors, and/or subcontractors with access to an applicant's, participant's, or tenant's information to maintain the confidentiality of any and all applicant, participant, and tenant records and information with which they may come into contact, as required by law.

D. The Parties' confidentiality obligations herein shall survive termination or expiration of this MOU for any reason.

XI. TERMINATION OF MOU

A PHA may terminate its participation in, and obligations under, this MOU with or without cause by providing thirty (30) days' written notice to the other Parties. A PHA's termination of participation in this MOU shall not terminate this MOU in its entirety, but it shall terminate the MOU with respect to the PHA that terminates its participation hereunder. If all PHAs terminate their participation in this MOU, either individually or collectively, this MOU shall be terminated in its entirety. In addition, CalOptima may terminate this MOU with or without cause by providing thirty (30) days' written notice to all participating PHAs prior to the effective date of termination. Except as provided otherwise hereunder, exercise by any PHA of the right to terminate participation in this MOU shall relieve the PHA of all further obligations under this MOU upon termination, except for those provisions that survive termination as stated herein. Except as provided otherwise hereunder, termination of this MOU shall relieve all Parties of all further obligations under this MOU upon termination, except for those provisions that survive termination as stated herein.

XII. GENERAL PROVISIONS

A. No change, modification, extension, or waiver of this MOU shall be effective unless in writing and signed by all Parties. If any law, rule, or regulation applicable to this MOU, or any interpretation thereof by any court, is modified or implemented during the term of the MOU in a way that materially changes the terms of the MOU ("**Regulatory Change**"), CalOptima may, upon written notice to PHAs, propose an amendment of the MOU to PHAs to the minimum degree necessary to comply with the Regulatory Change. If any PHA does not accept the proposed Regulatory Change, CalOptima may immediately terminate this MOU upon written notice to PHAs. This MOU represents the entire understanding of the Parties with respect to the subject matter herein and supersedes all prior agreements and understandings, whether written or oral, between the Parties concerning such terms.

B. If any provision of this MOU is held invalid or unenforceable by any court of law, the remaining provisions of this MOU shall nevertheless continue to be valid and

enforceable as though the invalid or unenforceable parts had not been included herein.

C. A PHA may not assign or delegate any obligations or rights under this MOU without the prior written consent of CalOptima.

D. This MOU shall be governed by the laws of the State of California, and the Parties consent to venue and personal jurisdiction over them in Superior Court in Orange County, California, and in U.S. District Court for the Central District of California, as applicable, for purposes of construction and enforcement of this MOU. The Parties shall comply with all applicable laws in performance of their obligations under this MOU.

E. Each Party warrants that it has the full right, power, and authority to enter into and fully perform its obligations under this MOU and that the execution, delivery, and performance of this MOU by that Party does not conflict with any other agreement to which it is a Party or by which it is bound.

F. Each Party has had the opportunity to have counsel of its choice examine the provisions of this MOU, and no implication shall be drawn against any Party by virtue of the drafting of this MOU.

G. This MOU may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall be deemed one and the same instrument.

H. If the Parties are unable to informally resolve any dispute arising out of or relating to this MOU, a Party, with the concurrence of all other Parties, may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California, in accordance with the commercial dispute rules then in effect of the Judicial Arbitration and Mediation Services ("JAMS"). The arbitration shall be conducted on an expedited basis by a single arbitrator. 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 any 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. In the event arbitration is mutually agreed to, the Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

I. CalOptima agrees to indemnify, defend, and hold harmless each PHA and its elected and appointed officials, officers, employees, and agents and those special districts and agencies for which County of Orange's Board of Supervisors acts as the governing Board from any third-party claims, demands, including defense costs, or liability of any kind or nature, including, but not limited to, personal injury or property damage, arising from or related to CalOptima's failure to perform its obligations under this MOU, gross negligence or intentional misconduct.

J. Each PHA agrees to indemnify, defend, and hold CalOptima, its elected and appointed officials, officers, employees, agents, directors, members, and/or affiliates harmless from any third-party claims, demands, including defense costs, or liability of any kind or nature, including, but not limited to, personal injury or property damage, arising from or related to that PHA's failure to perform its obligations under this MOU, gross negligence or intentional misconduct.

K. If judgment is entered against one Party by a court of competent jurisdiction because of the concurrent active negligence of the other Party or its officials, officers, directors, employees, or agents, the Parties agree that liability will be apportioned as determined by the court.

L. Each Party represents and warrants that the person executing this MOU on behalf of its organization is an authorized agent who has actual authority to bind its organization to each and every term, condition, and obligation of this MOU and that all requirements have been fulfilled to provide such actual authority.

M. Nothing herein contained shall be construed as creating the relationship of employer and employee, or principal and agent, between a PHA and any applicant or participant participating in this program, CalOptima, or any of CalOptima's agents or employees.

N. This MOU may be executed in two or more counterparts, each of which shall be deemed an original and all of which together shall constitute the same agreement. Facsimile, documents executed, scanned, and transmitted electronically, and electronic signatures shall be deemed original signatures for purposes of this MOU, with such facsimile, scanned, and electronic signatures having the same legal effect as original signatures.

XIII. SECURITY

A. The Parties agree to maintain the confidentiality of all information and records shared as a result of this MOU pursuant to all applicable laws relating to privacy and confidentiality that currently exist or exist at any time during the term of this MOU. The Parties represent, warrant, and covenant that they have implemented and will maintain during the term of this MOU administrative, physical, and technical safeguards to reasonably protect private and confidential participant and applicant information, to protect against anticipated threats to the security or integrity of data, and to protect against unauthorized physical or electronic access to or use of data. Such safeguards and controls shall include at a minimum:

1. Storage of confidential paper files that ensures records are secured, handled, transported, and destroyed in a manner that prevents unauthorized access.

2. Control of access to physical and electronic records to ensure data is accessed only by individuals with a need to know for the delivery of MOU services.

3. Control to prevent unauthorized access and to prevent employees of the Party from providing data to unauthorized individuals.

4. Firewall protection.

5. Use of encryption methods of electronic data while in transit from the Parties' networks to external networks, when applicable.

6. Measures to securely store all data, including, but not be limited to, encryption at rest and multiple levels of authentication and measures, to ensure data shall not be altered or corrupted by third parties. The Parties further represent and warrant that they have implemented and will maintain during the term of this MOU administrative, technical, and physical safeguards and controls consistent with state and federal security requirements.

B. At termination of this MOU and the records retention period required herein, whichever is later, if feasible, the Parties shall return or destroy all information received from the other Parties. If such return or destruction is not feasible, the Parties shall extend the protections of this MOU to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

XIV. SECURITY BREACH NOTIFICATION

A. All Parties shall have policies and procedures in place for the effective management of Security Breaches, as defined below. In the event of any actual, attempted, suspected, threatened, or reasonably foreseeable circumstance CalOptima or a PHA experiences or learns of that either compromises or could reasonably be expected to comprise CalOptima or PHA data through unauthorized use, disclosure, or acquisition of CalOptima or PHA data ("Security Breach"), the Party that has identified the potential Security Breach shall notify the other Party of its discovery within twenty four (24) hours. After such notification, the Party that has identified the potential Security Breach of the other Parties' data shall, at its own expense, promptly:

1. Investigate to determine the nature and extent of the Security Breach;

2. Contain the incident by taking necessary action, including, but not limited to, attempting to recover records, revoking access, and/or correcting weaknesses in security; and

3. Report to the other Party the nature of the Security Breach, the data used or disclosed, the person who made the unauthorized use or received the unauthorized disclosure, what has been done or will be done to mitigate any harmful effect of the unauthorized use or disclosure, and the corrective action that has been taken or will be taken to prevent future similar unauthorized use or disclosure.

B. The Party, whose data has been breached in violation of applicable law, at its sole discretion and on a case-by-case basis, will determine what actions are necessary in response to the breach and who will perform these actions. Actions may include but are not limited to: notifications; investigation and remediation costs, including notification of all whose personal information was disclosed; outside investigation; forensics; counsel; crisis management; and credit monitoring. In the event the Party, whose data has been breached, determines that additional action(s) are required, the other Party shall bear the reasonable costs to remedy the breach. In the event the Party, whose data has been breached, conducts additional actions(s) arising out of or in connection with a Security Breach, the other Party shall reimburse the Party, whose data has been breached, for costs associated to legally required actions.

XV. NOTICES

A. All notices required by this MOU shall be submitted to the addresses in this section. Any notice not related to termination of this MOU may be submitted electronically to the address set forth below.

Orange County Housing Authority

1501 E St. Andrew Place
Santa Ana, CA 92705

Anaheim Housing Authority
201 S Anaheim Boulevard
Suite 201, 2nd Floor
P.O. Box 3222
Anaheim, CA 92803-9987

Garden Grove Housing Authority
12966 Euclid St, Suite 150
Garden Grove 92840

Santa Ana Housing Authority
20 Civic Center Plaza
Santa Ana, CA 92701

CalOptima:
Attn: Contracting Department - Director of Contracting
505 City Parkway West
Orange, CA 92868
Email:

B. All mailed notices shall be deemed effective when in writing and deposited in the United States mail, first class, postage prepaid and addressed as above.

[*signature pages follow*]

In Witness Whereof, the Parties have signed this by their duly authorized representatives, effective as of the Effective Date.

CALOPTIMA HEALTH

_____
Signature

_____
Yunkyung Kim

_____
Chief Operating Officer

_____
Date

APPROVED AS TO FORM
[insert entity]

By: _____
[insert title]

Date: _____

ORANGE COUNTY HOUSING AUTHORITY
ORANGE COUNTY COMMUNITY RESOURCES

_____
Signature

Julia Bidwell
_____
Print Name

Executive Director
_____
Title

_____
Date

Approved as to Form:
Office of the County Counsel
Orange County, California

_____ _____
John Cleveland, County Counsel Date

ANAHEIM HOUSING AUTHORITY

_____

Signature

Grace Stepter

_____

Print Name

Executive Director

_____

Title

_____

Date

Approved as to Form:

_____ _____

Ryan Hodge, Deputy City Attorney Date

ATTEST:

By: _____

City Clerk

GARDEN GROVE HOUSING AUTHORITY

_____

Signature

Lisa Kim

_____

Print Name

Executive Director

_____

Title

_____

Date

Attest:

_____ _____

Secretary Date

SANTA ANA HOUSING AUTHORITY

_____
Signature

Michael L. Garcia

_____
Print Name

Executive Director

_____
Title

_____
Date

Approved as to Form:

_____ _____
Jose Montoya, Assistant City Attorney Date

ATTEST:

By: _____
Jennifer Hall, Recording Secretary

Exhibit A

CalAIM Housing and Health Services

Voluntary Consent Form to Release, Share, and Disclose Confidential Information

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2. To aid me in accessing the benefits available through CalAIM,[2] including case management, and assist in providing temporary and or/permanent housing opportunities.
3. To assist in making referrals for various health care benefits, including, but not limited to, CalAIM Enhanced Care Management and Community Supports.[3]
4. To monitor the services, I receive to ensure they are beneficial.

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[6] These services may include: housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post-hospitalization housing, recuperative care, respite services, day habilitation services, asthma remediation, medically tailored meals/medically-supportive food, community transition services/nursing facility transition to a home, personal care and homemaker services, environmental accessibility adaptations, and nursing facility transition/diversion to assisted living facilities such as residential care facilities for elderly and adult residential facilities. CalOptima will assist you in determining for which CalAIM services you are eligible.

Consent Form is effective on the date provided below. Unless otherwise revoked earlier in writing, this authorization expires five (5) years after the date you sign.

I understand that I may terminate this Voluntary Consent Form at any time by submitting a written notice to the Housing Authority. Termination of this Voluntary Consent Form will not apply to information that was shared under this Voluntary Consent Form prior to its termination. I confirm that I have read the preceding information, agree to its contents, and have received a copy of this form. I also understand that signing this form is voluntary and that I am not required to sign this form. Treatment, payment, or eligibility for benefits provided by the Housing Authority, CalOptima, and CalOptima's contracted Medi-Cal providers will not be affected if I do not sign this form. Any questions that I may have had have been answered fully and to my satisfaction. I am the individual indicated below, the individual's legal representative, or am otherwise authorized by the individual to sign the below and accept these terms on their behalf. If I am not the individual, I understand and agree that any references to "I", "you", or "my" are deemed to include the individual.

Head of Household or Legal Representative (Print Full Legal Name)		Signature	Date
Home Address	City	State	Zip Code
Email Address	Date of Birth	Telephone number	

Co-Head/Other Adult or Legal Representative (Print Full Legal Name)		
Signature	Date	
Email Address	Date of Birth	Telephone number

Other Adult or Legal Representative (Print Full Legal Name)		
Signature	Date	
Email Address	Date of Birth	Telephone number

Other Adult or Legal Representative (Print Full Legal Name)		
Signature	Date	
Email Address	Date of Birth	Telephone number

Exhibit A

CalAIM Housing and Health Services

Voluntary Consent Form to Release, Share, and Disclose Confidential Information

Orange County Health Authority dba CalOptima Health is a public agency that provides health care coverage for Orange County residents who are eligible for Medi-Cal. CalOptima Health is working alongside the **GARDEN GROVE HOUSING AUTHORITY** (Housing Authority) to ensure that any interested housing choice or special purpose voucher applicants/participants are not only enrolled for Medi-Cal, if eligible, but also, receiving any and all benefits that they are eligible for and interested in receiving, including available housing navigation opportunities.

By signing below, I voluntarily agree to allow the Housing Authority to disclose to CalOptima Health the minimum information necessary about me to confirm enrollment in Medi-Cal and provide the services described herein, including confidential information and personally identifying information,[7] for the following purposes:

1. To determine my current enrollment status in Medi-Cal or my interest in registering for Medi-Cal.
2. To aid me in accessing the benefits available through CalAIM,[8] including case management, and assist in providing temporary and or/permanent housing opportunities.
3. To assist in making referrals for various health care benefits, including, but not limited to, CalAIM Enhanced Care Management and Community Supports.[9]
4. To monitor the services, I receive to ensure they are beneficial.

By signing below, I further acknowledge and agree that CalOptima Health may contract with third party Medi-Cal providers to provide services to me. For purposes of this form, CalOptima's contracted Medi-Cal providers include providers that perform the following categories of services: CalAIM Enhanced Care Management and Community Supports. I understand, agree, and authorize Housing Authority and CalOptima to disclose information about me for the purposes described above. Please note that the list of CalOptima's contracted Medi-Cal providers can change frequently and without notice, and therefore the website should be consulted for the most recent list: https://www.caloptima.org/en/ForMembers/Medi-Cal/FindAProvider. This Voluntary

[7] For example, this information may include full name, date of birth, social security number and contact information to assist in coordinating Medi-Cal related benefits or CalOptima services.

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1. To determine my current enrollment status in Medi-Cal or my interest in registering for Medi-Cal.
2. To aid me in accessing the benefits available through CalAIM,[11] including case management, and assist in providing temporary and or/permanent housing opportunities.
3. To assist in making referrals for various health care benefits, including, but not limited to, CalAIM Enhanced Care Management and Community Supports.[12]
4. To monitor the services, I receive to ensure they are beneficial.

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Attachment to the February 1, 2024 Board of Directors Meeting – Agenda 18

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Anaheim Housing Authority	201 S Anaheim Blvd Unit 201	Anaheim	CA	92805
Garden Grove Housing Authority	12966 S Euclid St #150	Garden Grove	CA	92840
Santa Ana Housing Authority	20 Civic Center Plaza #200	Santa Ana	CA	92701
Orange County Housing Authority	1501 E St Andrew Pl	Santa Ana	CA	92705

Motion Tabled Until March 7, 2024

CalOptima Health Board Action Agenda Referral

Action To Be Taken February 1, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
19. Select and Enter into Grant Agreements with Street Medicine Providers

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 Request for Qualifications (RFQu) Evaluation Committee recommendation for the street medicine providers for the cities of Anaheim and Costa Mesa.
2) Authorize the Chief Executive Officer or designee to execute two-year grant agreements in an amount not to exceed $5.0 million in aggregate to expand CalOptima Health's Street Medicine Program with awarded Medi-Cal street medicine providers.
3) Appropriate up to $1.8 million in existing reserves to fund the street medicine provider grant agreements.
4) Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background
On March 17, 2022, CalOptima Health's Board (Board) committed $8 million from the Homeless Health Initiatives Reserve for purposes of Street Medicine. On May 5, 2022, the Board approved the street medicine scope of work. On November 3, 2022, the Board authorized the Chief Executive Officer to execute a contract with Healthcare In Action to provide street medicine services. The pilot launched in Garden Grove on April 1, 2023. Due to the success of the pilot, on October 5, 2023, the Board authorized CalOptima Health staff to release a notice of interest opportunity to Orange County cities to identify interested cities to host the expansion of CalOptima Health's Street Medicine Program. CalOptima Health launched the RFQu for street medicine providers on November 9, 2023. On December 7, 2023, the Board authorized CalOptima Health to expand its Street Medicine Program to Anaheim and Costa Mesa.

Discussion
On January 3, 2024, a committee of evaluators from CalOptima Health reviewed and scored the submitted proposals received based on determined criteria as it pertains to the street medicine services RFQu. The evaluation committee recommends that Street Medicine Grant Agreements be awarded to the following Medi-Cal contracted providers:

- Healthcare in Action in the city of Anaheim.
- Celebrating Life Community Health Center in the city of Costa Mesa.

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Similar to the city of Garden Grove program, the city of Anaheim and city of Costa Mesa programs will be designed to become financially sustainable through the implementation of the California Advancing and Innovating Medi-Cal (CalAIM) services. CalOptima Health staff determined that it takes approximately two years of operations to achieve this sustainability. Therefore, staff have developed a two-year grant agreement.

To fund the grant agreements, staff will utilize approximately $3.2 million remaining for the Street Medicine Initiative in the Homeless Health Initiatives Reserve and requests an additional appropriation of up to $1.8 million from existing reserves. CalOptima Health plans to enter into grant agreements with the awarded Medi-Cal providers in March 2024, facilitate the brief program design process with each participating city, and then launch street medicine services in the respective cities in July 2024.

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

Fiscal Impact

A Board action from March 17, 2022, committed $8.0 million in Homeless Health Initiative funding under the "Authorize mobile health team to respond to all homeless providers" category for the purposes of street medicine. Approximately $3.2 million remains and is available for allocation for the grant agreements.

An appropriation of up to $1.8 million from existing reserves will provide funding for the remainder of the two-year street medicine provider grant agreements, totaling $5 million. CalOptima Health reserves the right to adjust funding for grantees or to recoup funds for lack of demonstrating effort and performance against targeted measures.

Rationale for Recommendation

To engage CalOptima Health members experiencing homelessness, where they are and on their own terms, and to reduce or eliminate barriers to medical and social care, CalOptima Health staff recommends entering into grant agreements with Healthcare in Action and Celebrating Life Community Health Center to provide street medicine services in the cities of Anaheim and Costa Mesa.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Draft CalOptima Health Street Medicine Grant Agreement
2. Entities Covered by this Recommended Board Action

Board Action(s)

/s/ Michael Hunn *01/25/2024*
Authorized Signature **Date**

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GRANT AWARD AGREEMENT

BETWEEN

CALOPTIMA HEALTH

AND

«Provider_Grantee_Name_»

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THIS GRANT AWARD AGREEMENT ("**Agreement**") is made and entered into as of «Effective_Date_» ("**Effective Date**"), by and between Orange County Health Authority, a county organized health system for the County of Orange, California dba CalOptima Health ("**CalOptima**), and «Provider_Grantee_Name_» ("**Grantee**"), a «Corporation_Type_». CalOptima and Grantee may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima is a public agency formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

B. CalOptima's mission is to serve member health with excellence and dignity, respecting the value and needs of each person.

C. CalOptima has designated certain Board-approved Homeless Health Care Initiative funds and Housing and Homeless Incentive Program (HHIP) funds to fund CalOptima's Street Medicine Program.

D. Grantee desires to provide support and/or enhanced benefits to Members, in accordance with Grantee's grant project described in Attachment A ("**Grant Project**") described in Grantee's Proposal.

E. CalOptima finds that the Grant Project is a community program that supports and is compatible with CalOptima's mission and desires to assist Grantee in undertaking its project by providing financial support described in Attachment B ("**Grant Award**") in accordance with CalOptima's policies and procedures, subject to Grantee's compliance with the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, it is agreed by and between the Parties hereto as follows:

I. GRANTEE OBLIGATIONS

1.1 **Grantee Eligibility**. Grantee hereby warrants that it is, and shall remain throughout the term of this agreement, a «Corporation_Type_» registered in «State_in_which_Company_is_Registered».

1.2 **Grantee Activities.** Grantee agrees (i) to diligently pursue the Grant Project, as specified in Attachment A, attached hereto and incorporated herein by this reference, (ii) to use the Grant Award solely for activities as identified in Attachment A, ("**Grant Activities**"), (iii) to expend funds in accordance with this Agreement and all federal, state, and local statutes and regulations, and (iv) to return any grant funds determined to have been improperly paid, in order to avoid forfeiture of the entire Grant Award. In the event of any conflict between the Grant Proposal in Attachment A and the rest of this Agreement, this Agreement, including all Attachments, shall prevail.

1.3 **Unauthorized Use of Funds**. Grantee shall use Grant Funds consistent with this Agreement and the approved Grant Activities. CalOptima retains the right to recover any and all Grant Award funds if it (or any of its regulators) determines that any portion of the Grant Award was not expended as provided under the terms of this Agreement or applicable federal and state laws, regulations, guidance and/or funding source requirements.

1.4 **Limitations on Subcontracting**. The experience, knowledge, capability, and reputation of Grantee, its directors and employees were a substantial inducement for CalOptima to enter into this Agreement. Grantee shall not contract with any entity to perform the Grant Project without written approval of CalOptima. Grantee shall be fully responsible to CalOptima for the acts and omissions of its subcontractor(s), if any, as it is for the acts and omissions of persons directly employed by Grantee. In the event that CalOptima approves any subcontracting, nothing contained in this Agreement shall create any contractual relationship between any subcontractor(s) and CalOptima. All persons engaged in the work under the Grant Proposal by Grantee will be considered employees of Grantee. CalOptima will deal directly with and make payment hereunder solely to Grantee.

1.5 **Subcontracts.** To the extent that subcontracting is authorized by CalOptima under this Agreement, Grantee shall assure that all subcontracts are in writing and include any requirements of this Agreement that are appropriate to the service or activity and assure that the subcontract shall not terminate legal liability of Grantee under this Agreement.

1.6 **Communications Provisions**. Grantee must comply with CalOptima's Guidelines for Endorsements and Use of CalOptima Name or Logo policy.

1.6.1 **Use of CalOptima name or logo**: Grantee shall submit requests to CalOptima's CalAIM department, in writing, at least twenty-one (21) calendar days in advance of the date for which use of the name or logo is required. Upon receipt of a complete request for use of the CalOptima name or logo, CalOptima's CalAIM department shall review and analyze the request with input from appropriate internal departments. For more information or to submit a request, email calaim@caloptima.org. The CalAIM department shall submit a request for use of the CalOptima name or logo to the Communications Department for review and consideration and will notify Grantee in writing after a determination has been made.

1.6.2 **All other uses of CalOptima's name:** Grantees may not use CalOptima's name, including in the title of Grantee's program, without prior written approval from CalOptima.

II. GRANT PAYMENTS

2.1 **Grant Payments.** Payment of the Grant Award to Grantee under this Agreement will be as set forth in Attachment B, incorporated herein by this reference, which shall be payment in full for the Grant Project. Grantee acknowledges and agrees that this is a single Grant Award and that nothing herein obligates CalOptima to any further funding, whether for the Grant Project or future related or unrelated activities. The Parties acknowledge that the source of Grant Award funding is existing reserve funds, and not Department of Health Care Services ("**DHCS**") funds, and as such the payments made hereunder are not subject to DHCS State Contract terms or federal or state claims processing requirements. Notwithstanding the foregoing, Grantee acknowledges and agrees that the

Grant Award must be used for support and enhanced benefits to CalOptima Medi-Cal members, and is subject to the terms of this Agreement and CalOptima's policies and procedures, as applicable.

2.2 **Grant Award Use Limitations**. Grantee acknowledges and agrees that the Grant Award may not be used for achievement of milestones that have been previously paid for or will be paid for by the state or federal government or any other source. Further, Grantee acknowledges and agrees that it will not use the Grant Award to reimburse costs or liabilities it incurred prior to the date of the Grant Award.

III. WARRANTIES/COMPLIANCE WITH CALOPTIMA AND REGULATORY AGENCY RULES AND REGULATIONS

3.1 **Compliance with Applicable Laws**. In carrying out the Grant Project, Grantee shall comply with the CalOptima policies and procedures, and all other applicable CalOptima policies, as made available to Grantee on CalOptima website, as well as all federal, state and local laws, rules, and regulations.

3.2 **Health Insurance Portability and Accountability Act (HIPAA) Compliance**

3.2.1 Grantee and CalOptima shall comply with Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") and the Health Information Technology for Economic and Clinical Health ("**HITECH**") Act and any regulations promulgated thereunder ("**HIPAA Requirements**") in performing their obligations under the Agreement.

3.2.2 If required by HIPAA Requirements, the Parties agree to execute CalOptima's HIPAA Business Associate Agreement, which shall be incorporated into this Agreement, and comply with the terms and conditions thereof.

3.3 **Confidentiality of Information**

3.3.1 Grantee and its employees, agents, and subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to Grantee, its employees, agents, or subcontractors as a result of this Agreement. Grantee and its employees, agents, and subcontractors shall not use such identifying information for any purpose other than carrying out Grantee's obligations under this Agreement. Grantee and its employees, agents, and subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Grantee shall not disclose, except as otherwise specifically permitted by this Agreement or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, including without limitation a finger or voice print or a photograph.

3.3.2 Notwithstanding any other provision of this Agreement, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 C.F.R. Section 431.300 *et seq.*, Welfare and Institutions Code Section

14100.2, and any regulations adopted thereunder. For the purpose of this Agreement, all information, records, data, and data elements collected and maintained for the operation of the Agreement and pertaining to Members shall be protected by Grantee from unauthorized disclosure. Grantee may release Member medical records in accordance with applicable law pertaining to the release of this type of information. Grantee is not required to report requests for medical records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Agreement that is obtained by Grantee, its employees, agents or subcontractors, Grantee:

(a) Will not use any such information for any purpose other than carrying out the express terms of this Agreement,

(b) Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for medical records in accordance with applicable law,

(c) Will not disclose except as otherwise specifically permitted by this Agreement, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 C.F.R. Section 431.300 et seq., Welfare and Institutions Code Section 14100.2, and regulations adopted there under, and

(d) Will, at the termination of this Agreement, return all such information to CalOptima or maintain such information according to written procedures sent to the Grantee by CalOptima for this purpose.

IV. RECORDS AND REPORTS

4.1 **Maintain Complete Books and Records.** Grantee shall create and maintain such books and records relating to the Grant Activities performed under this Agreement as required by applicable laws and CalOptima policies and procedures. All financial records shall be maintained in accordance with generally accepted accounting principles ("**GAAP**"). Records generated in the course of carrying out this Agreement shall be maintained for ten (10) years from the date of the grant award, or the date of the completion of any audits related to this Agreement, whichever is later. Grantee shall provide CalOptima or its designated agents, within ten (10) calendar days of a written request, information or copies of records necessary to verify and substantiate compliance with the terms of this Agreement. Grantee shall pay all duplication and postage costs associated with any audits and/or reviews necessary to ensure compliance with this Agreement or CalOptima's regulatory requirements. This Section 4.1 shall survive the termination of this Agreement.

4.2 **Reports.** Grantee shall submit all reports as specified in Attachment C, "Grant Report Schedule," attached hereto and incorporated herein by this reference.

4.3 **Audit.** CalOptima shall have the right to audit, or to have audited by an independent third party, all Grant Project expenses. Grantee shall fully cooperate with CalOptima or its auditor and shall refund to CalOptima any amounts found to have been improperly expended from the Grant Award within thirty (30) days of the notice of such improper expenditures. Grantee shall be entitled to challenge any audit finding through appealing through CalOptima's grievance process.

V. INSURANCE AND INDEMNIFICATION

5.1 **Grantee Comprehensive General Liability ("CGL")/Automobile Liability**. Grantee at its sole cost and expense shall maintain 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.

5.2 **Workers Compensation Insurance.** Grantee at its sole cost and expense shall maintain workers compensation insurance within the limits established and required by the State of California and employer's liability insurance with minimum limits of liability of one million dollars ($1,000,000) per occurrence/one million dollars ($1,000,000) aggregate per year.

5.3 **Insurer Ratings**. Insurance required under this Agreement shall be provided by an insurer:

(a) Rated by Best's Guide Rating with a rating of B 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 licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code Section12180.7.

5.4 **Captive Risk Retention Group/Self Insured.** Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self-insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's or self-insured's audited financial statements and approves the waiver.

5.5 **Cancellation or Material Change.** The Grantee shall not of its own initiative cause such insurances as addressed in this Article to be canceled or materially changed during the term of this Agreement without prior notification to CalOptima.

5.6 **Certificates of Insurance**. Prior to execution of this Agreement, Grantee shall provide Certificates of Insurance and additional insured endorsements to CalOptima showing the required insurance coverage and further providing that CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and Grantee's coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

5.7 **Indemnification.** Grantee shall defend, indemnify and hold harmless CalOptima and its officers, directors, and employees from and against any and all claims (including attorneys' fees

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and reasonable expenses for litigation or settlement) that are related to or arise out of the Grantee's negligence, willful performance or non-performance or breach of any duties or obligations of Grantee arising under this Agreement. Neither termination of this Agreement nor completion of the acts to be performed under this Agreement shall release Grantee from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.8 **Notification of Claims.** CalOptima agrees to promptly notify Grantee of any claims or demands which arise and for which indemnification or Grantee's duty to defend hereunder is sought.

5.9 **Termination.** The terms of this Article V. shall survive the termination of this Agreement.

VI. TERM AND TERMINATION

6.1 **Term of Agreement.** This Agreement will commence on the Effective Date and will remain in effect up to and including «Term_Date», or completion of the Grant Project, whichever occurs last.

6.2 **Termination.** If Grantee fails to fulfill any of its duties and obligations under this Agreement, including but not limited to: (i) committing acts of unlawful discrimination; (ii) engaging in prohibited marketing activities; and, (iii) committing fraud or abuse relating to any obligation, duty or responsibility under this Agreement (such as falsifying data in any reports; failing to maintain eligible status (non-profit in good standing), paying for services to non-Medi-Cal Member out of grant funds, etc.), CalOptima may terminate this Agreement for cause pursuant to Section 6.3.

6.3 **Termination for Cause**. Notwithstanding and in addition to any other provisions of this Agreement, CalOptima may terminate this Agreement for cause effective upon thirty (30) calendar days' prior written notice. Cause shall include, but shall not be limited to, the actions set forth in Section 6.2. Grantee may appeal CalOptima's decision to terminate the Agreement for cause by filing a complaint pursuant to CalOptima policies and procedures. Grantee shall exhaust this administrative remedy, including requesting a hearing if permitted under CalOptima policies and procedures, for any and all Grantee complaints before commencing any civil action.

CalOptima's rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or this Agreement.

6.4 **Automatic Termination.** This Agreement shall terminate automatically if the DHCS State Contract between CalOptima and DHCS is terminated.

6.5 **Bankruptcy.** CalOptima or Grantee may terminate this Agreement with thirty (30) day written notice to the other Party in the event (i) a petition is filed in a court of record jurisdiction to declare either Party bankrupt or for reorganization under the bankruptcy laws of the United States or any similar statute of a state of the United States, or (ii) if a trustee in bankruptcy or a receiver is appointed for such Party, and such petition, trustee, or receiver, as the case may be, is not dismissed within one hundred and twenty (120) days thereof.

VII. GENERAL PROVISIONS

7.1 **Interpretation of Agreement Language.** CalOptima has the right to final interpretation of the Agreement language when disputes arise. Grantee has the right to appeal disputes concerning Agreement language to CalOptima.

7.2 **Waiver.** Any failure of a Party to insist upon strict compliance with any provision of this Agreement shall not be deemed a waiver of such provision or any other provision of this Agreement. To be effective, a waiver must be in writing that is signed and dated by the Parties.

7.3 **Assignment.** Neither this Agreement nor any of the duties delegated herein shall be assigned, delegated or transferred by Grantee without the prior written consent of CalOptima. CalOptima may assign this Agreement and its rights, interests and benefits hereunder to any entity that has at least majority control of CalOptima or to any entity whose financial solvency has been approved by Grantee, which approval shall not be unreasonably withheld. If required, any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the appropriate state and federal agencies.

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

7.5 **Integration of Entire Agreement.** This Agreement contains all of the terms and conditions agreed upon by the Parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations, or representations of or between the Parties, either oral or written, relating to the subject matter of this Agreement that are not expressly set forth in this Agreement are null and void and of no further force or effect. All attachments to this Agreement are considered part of this Agreement and are hereby incorporated herein.

7.6 **Independent Agreement.** Nothing in this Agreement shall affect any other contractual relationships between the Parties, such as an agreement for the provision of medical services to Members. No monies paid under this Agreement may be used for the provision of services

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that are payable under a different contract between the Parties, or for any other purpose beyond the Grant Project as set forth in Attachment A.

7.7 **Invalidity or Unenforceability.** The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other term or provision.

7.8 **Amendment.** CalOptima may amend this Agreement immediately upon written notice to Grantee in the event such amendment is required in order to maintain compliance with applicable state or federal laws. Other amendments to the Agreement shall be effective only upon mutual, written agreement of the Parties.

7.9 **No Waiver of Immunity or Privilege**. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

7.10 **Choice of Law.** This Agreement shall be governed by and construed in accordance with the laws of the State of California. The Parties consent to the jurisdiction of the California Courts with venue in Orange County, California.

7.11 **Force Majeure.** Both Parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Agreement as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war, but excluding labor disputes, (a "**Force Majeure Event**") provided such Party uses commercially reasonable efforts to mitigate its effects and gives prompt written notice to the other Party. The time for the performance shall be extended for the period of delay or inability to perform due to such occurrences up to a period of ten (10) days at which time the Party unaffected by the Force Majeure Event may immediately terminate this Agreement upon written notice to the other Party without liability.

7.12 **Interpretation**. Each Party has had the opportunity to have counsel of its choice examine the provisions of this Agreement, and no implication shall be drawn against any Party by virtue of the drafting of this Agreement.

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

7.14 **No Liability of County of Orange.** As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the Grantee hereby acknowledge and agree that the obligations of CalOptima under this Agreement are solely the obligations of CalOptima, and that the County of Orange, State of California, shall have no obligation or liability therefor.

7.15 **Non-liability of Officials and Employees of CalOptima**. No official or employee of CalOptima shall be personally liable to Grantee in the event of any default or breach by CalOptima, or for any amount that may become due to Grantee, or any obligation under the terms of this Agreement.

7.16 **Time of Essence**. Time is of the essence in the performance of this Agreement.

7.17 **Authority to Execute**. The persons executing this Agreement on behalf of the Parties warrant that they are duly authorized to execute this Agreement, and that by executing this Agreement, the Parties are formally bound.

7.18 **Counterparts**. This Agreement may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall be deemed one and the same instrument.

7.19 **Notices.** All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the Party to whom notice is given, or seventy-two (72) hours after mailing by United States mail first class, Certified Mail or Registered Mail, return-receipt-requested, postage-prepaid, addressed to the party to whom notice is to be given and such Party's address as set forth below or such other address provided by notice.

To: CalOptima Health
Attention: CEO
C/O: CalAIM
505 City Parkway West
Orange, California 92868

To: Grantee
«Provider_Grantee_Name_»
«Send_Correspondence_to_This_Person_First» «Last_Name»
«Title»
«Address»
«City», «State» «Zip»

[SIGNATURES ON FOLLOWING PAGE]

VIII: SIGNATURES

IN WITNESS WHEREOF, the Parties have, by their duly authorized representatives, executed this Agreement, to be effective the date first written above:

FOR GRANTEE:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
«Signatory»_____	«CalOptima_Health_Signatory»____
PRINT NAME	PRINT NAME
«Title_of_Signatory»_____	«CalOptima_Health_Signatory_Title»
TITLE	TITLE
_____	_____
DATE	DATE

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ATTACHMENT A
Grant Project

Grantee agrees to implement the agreed upon scope of work described in this Attachment A.

1. **Overview of the Grant Program**.

Grantee will operate CalOptima's Street Medicine Program in <<insert city>>, which pairs three, integrated, key components: (1) outreach and engagement; (2) coordinated medical care that meets people where they are; and (3) Enhanced Care Management ("**ECM**") and Housing Navigation. Together these integrated components address acute health concerns and deploy integral preventative care, but also move beyond stop-gap medical services to build the types of relationships that support a person's move to a home.

Grantee's outreach and engagement teams will consistently visit individuals in each of the encampments or hotspots in the selected service area of <<insert city>>. Some medical visits, but likely not all, will be pre-identified by Grantee's outreach and engagement teams during routine canvassing. During Grantee's encounters, the medical teams will provide an array of medical services and will attempt to understand the medical and psychosocial histories of individuals to best serve them over time. Problem-solving techniques will be used to identify strengths and existing support networks to help individuals maintain their health. Every outreach and engagement touchpoint will include an attempt to connect them to housing services.

These services together will accomplish the following outcomes:

- Provide participants with point-of-care services thereby reducing emergency department visits by 40%
- Enroll 75% of unenrolled eligible participants into Medi-Cal
- Connect 80% of participants to an active medical home with a primary care physician
- Connect 90% of participants with ECM and Housing Navigation
- Transition 25% participants to a shelter or other housing option

CalOptima recognizes that Grantee does not have complete control over achieving these targets and will not penalize Grantee for not achieving these targets, assuming Grantee demonstrates satisfactory effort on their part to achieve them, as determined by CalOptima. This is a new project and the targets are set to track our success against a goal; CalOptima understands that in working through the development of a new services, changes and unforeseen challenges can impact the collective ability to meet stated goals.

CalOptima has developed a Street Medicine Operations Manual ("**Operations Manual**") to detail CalOptima's Street Medicine Program. Grantee must follow the Operations Manual in order to be in compliance with this Grant Project and Agreement. CalOptima may periodically update the Operations Manual. These updates are essential to ensure that CalOptima's processes align with industry best practices, regulatory requirements, and the evolving needs of the partnership between the Parties. The updates to the Operations Manual may include, but are not limited to, changes in policies, procedures, compliance requirements, or service delivery protocols. These modifications are aimed at enhancing the efficiency, effectiveness, and compliance of the Parties' collaborative

activities. Whenever updates to the Operations Manual occur, CalOptima is committed to communicating these changes within thirty (30) days. To streamline communication and ensure that updates are received and acknowledged in a timely manner, Grantee shall confirm its receipt and understanding of the updated Operations Manual within one week. Grantee shall implement operational changes within a timely manner, but in no event longer than thirty (30) days, to ensure that the Parties' collaboration remains seamless, compliant, and aligned with the shared objectives. If the Grantee encounters any challenges or requires clarification during the implementation process, CalOptima is readily available to provide assistance and address any queries.

2. **Grant Program Requirements**. Grantee shall do all of the following:

Staff the Team

1. Hire and staff the team as described in the Operations Manual.
    a. Initial staffing required to launch the team, including the Project Manager, must be hired within three (3) months of the Effective Date.
2. Purchase and outfit the identified mobile medical unit from the vendor identified by CalOptima with the wrap design provided by CalOptima within three (3) months of the Effective Date.
3. Confirm all staff are trained in trauma informed care and other best practice philosophies (within one (1) month of hire).

Partnership Development

1. Develop a working partnership with key stakeholders, relevant Orange County departments, and emergency responders in <<insert city>> and Orange County to identify encampments, hotspots, and key areas where people experiencing homelessness have established residence in <<insert city>>.
2. Coordinate a set schedule for each outreach team and medical team to visit these key sites during the week.
3. Develop a working partnership with a local federally qualified health center ("**FQHC**"), or FQHC look-alike.
4. Develop partnerships with key stakeholders and service providers in <<insert city>> to make referrals and connect to the existing continuum of care.
5. Build collaborative partnership with Be Well and their mobile response units, as applicable.

Care Scheduling & Delivery

1. Identify, launch, and utilize a scheduling system for planning out service delivery.
2. Provide additional visits beyond those already scheduled by Grantee's canvassing team, as needed.
3. Design and execute a ramp up plan to deliver medical and social services in the field (billed through a separate contract and claims process) for 40 hours/week in the field.
4. Outreach to and engage unsheltered individuals through this project:
    a. 50 individuals by month 6 of the Grant Project
    b. 150 individuals by month 12 of the Grant Project
    c. 250 individuals by month 18 of the Grant Project
    d. 300 individuals by 24 months of the Grant Project

5. Become the ECM and/or Community Supports ("**CS**") provider for unsheltered individuals (billed through a separate contract and claims process with CalOptima):
    a. 50 individuals by month 6 of the Grant Project
    b. 125 individuals by month 12 of the Grant Project
    c. 150 individuals by month 18 of the Grant Project
    d. 200 individuals by month 24 of the Grant Project

Connecting & Supportive Services

1. Use CalOptima Connect to connect individuals with ECM and CS services.
2. Connect individuals to transportation, as needed, for appointments and other services.
3. Connect individuals to local shelters.
4. Pending approval by the Orange County Continuum of Care oversight group, enter patients into the Homeless Management Information System and Coordinated Entry System for housing placement (have account access and training within 3 months).
5. Connect individuals to Social Service Agency to enroll in Medi-Cal, if not already covered.
6. Connect individuals to other supportive services.

Documentation and Invoicing

1. Submit quarterly reports to CalOptima, as specified by CalOptima and required by this Agreement, that cover the following:
    a. Number of unique persons served.
    b. Number of total visits provided.
    c. Number of referrals and linkages to ECM and CS.
    d. Number of transports coordinated.
    e. Number referred to clinic partner or other physical clinic locations.
    f. Number of individuals referred to temporary housing units, including shelter, recuperative care, and transitional housing facilities.
    g. Breakdown of services provided in the field (mobile clinic visits, street visits, telehealth, etc.)
    h. Number of individuals enrolled and/or confirmed in HMIS and CES.
    i. Number of individuals referred to SSA and enrolled in Medi-Cal.
2. Submit other reports as established in the Operations Manual and this Agreement.

Media & Branding

CalOptima will serve as the media and branding lead for the Grant Project and as such will spearhead discussions and initiatives related to media engagement, ensuring effective communication and representation of the Parties' collective endeavors. While collaboration and input from Grantee are highly valued, CalOptima is responsible for media-related decision-making. Should Grantee be contacted by a media organization about a possible media opportunity, Grantee must contact CalOptima with information about the opportunity for CalOptima's consideration and consent prior to any participation. Further, CalOptima will provide Street Medicine co-branded items designed to enhance the safety of both CalOptima's dedicated staff and the unhoused individuals the Parties serve. CalOptima anticipates that the Grantee's staff will actively participate in wearing and using these branded items, fostering a cohesive and unified presence as the Parties collectively address the unique needs of the unhoused. This requirement also extends to the Street Medicine

mobile unit, which will feature an exterior designed by CalOptima to promote a consistent look across multiple cities and include co-branding with provider partners.

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ATTACHMENT B

GRANT PAYMENT

CalOptima has made a Grant Award to Grantee in the amount of «Total_Grant_Amount_Written» («Total_Grant_Amount_Numeric»), which shall be the maximum amount payable for the Grant Project and which shall be paid following execution of the Agreement in the time and manner set forth below.

Payments: Payments under this Agreement shall be made in «Number_of_Payments». «Payment_Schedule»

Return Funds: Grantee shall refund to CalOptima any funds that are found to not have been utilized in accordance with the requirements of this Agreement. CalOptima shall have the right to audit, or to have audited by an independent third party, all Grant Project expenses. Grantee shall fully cooperate with CalOptima or its auditor and shall refund to CalOptima any amounts found to have been improperly expended from the Grant Award within thirty (30) days of the notice of such improper expenditures.

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ATTACHMENT C
REPORT SCHEDULE

Purpose of Grant Reports

In an effort to help ensure successful grant outcomes, CalOptima actively monitors and evaluates grant progress through monthly meetings with Grantee and requires that Grantee submit a final report. These reports are intended to help both CalOptima and Grantee appraise progress toward funding objectives.

Grant Report Requirements

All grant recipients must complete the Grant Report Form provided through written communication with CalOptima's CalAIM department. Please note that successful completion of reports are a condition of grant funding and incomplete reports will delay the disbursement of future grant payments, if multiple payments are being dispersed.

Report Submission Schedule

This grant requires the submission of «Number_of_Payments» over the duration of the project timeframe as follows:

- **Semi-Annual Progress Report** «SemiAnnual_Progress_Reports».
    - Specific due dates and Reporting Periods Covered:
        - Semi-Annual Report #1 -
        - <<MANUALLY INSERT>>

- **Final Report** will be due within thirty (30) calendar days after the end of this Grant Agreement.
    - Specific due date and Reporting Period Covered:
        - «Final_Report»

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Healthcare In Action	3800 Kilroy Airport Way, Suite 100	Long Beach	CA	90806
Celebrating Life Community Health Center	27800 Medical Center Rd. Suite 110 and 109	Mission Viejo	CA	92691

CalOptima Health Board Action Agenda Referral

Action To Be Taken February 1, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
20. Approve Actions Related to Expanding Intergovernmental Transfer Funding Partners

Contact
Donna Laverdiere, Executive Director, Strategic Development, (714)-986-6981

Recommended Action
Direct the Chief Executive Officer, or designees, to outreach to additional entities eligible to participate in the Intergovernmental Transfer (IGT) Voluntary Rate Range Program in order to maximize sources of funding for Medi-Cal programs, thereby expanding access to services for members and supporting fair reimbursement levels for providers that serve the community.

Background
The IGT Voluntary Rate Range Program allows the Department of Health Care Services (DHCS) and CalOptima Health to secure additional Medi-Cal dollars for eligible Orange County governmental entities. Eligible entities include:

- Counties;
- Cities;
- Special purpose districts, i.e. fire districts;
- State university teaching hospitals; and
- Other political subdivisions of the state, i.e. school districts.

For each IGT transaction, DHCS identifies the estimated member months for rate categories (*e.g.*, adult, adult optional expansion, child, long term care, seniors and persons with disabilities, and whole child model) and provides the total amount available for Orange County to contribute through funding entities. To receive funds, eligible governmental entities provide a voluntary contribution to DHCS, which is then used to obtain a federal match. DHCS distributes the funds and the match to the eligible entities through CalOptima Health.

CalOptima Health has participated in the IGT Voluntary Rate Range Program since 2010. For the first four IGTs, CalOptima Health partnered only with University of California, Irvine Health (UCI Health). Since then, additional Orange County eligible organizations have decided to participate as funding entities for the program. The six entities listed below currently participate:

- UCI Health;
- County of Orange;
- City of Huntington Beach (recent partnership started in 2023);
- City of Newport Beach;
- City of Orange; and
- First 5 Orange County (formerly known as the Children and Families Commission).

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CalOptima Health currently participates at 100% of the allowable non-federal share IGT amount for Orange County.

Discussion
Given the increasing membership at CalOptima Health, staff recommends sharing information about the IGT Voluntary Rate Range Program to additional eligible funding entities as identified by DHCS.

In order to educate eligible governmental entities, CalOptima Health will implement an outreach strategy that will notify eligible entities in Orange County of the funding opportunity to participate in the IGT Voluntary Rate Range program and conduct two educational webinars in February 2024 highlighting the IGT process and program requirements. Staff will return to the Board of Directors in Spring of 2024 and provide a report on the outcome of the outreach efforts and request approval of the additional potential IGT funding partners when the next funding round becomes available.

Fiscal Impact
Staff anticipates Calendar Year 2023 (IGT 13) and future IGTs will be net budget neutral to CalOptima Health. CalOptima Health will retain a 2% administrative fee of net proceeds to offset expenses for the administration of the program. The remaining net proceeds will be distributed to the participating IGT funding entities.

Rationale for Recommendation
Expanding outreach to additional eligible entities will potentially allow new participation in the IGT program and reduce uncompensated costs of providing health care services to CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2022, September 7, 2023

/s/ Michael Hunn *01/26/2024*
Authorized Signature **Date**

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

16. Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2022

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Peter Bastone, Chief Strategy Officer, (714) 246-8549

Recommended Actions

Authorize the following activities to secure Medi-Cal funds through the Voluntary Rate Range Intergovernmental Transfer (IGT) for Calendar Year 2022 (IGT 12):

1. Submission of a proposal to the California Department of Health Care Services (DHCS) to participate in IGT 12;
2. Pursuit of funding partnerships with the University of California-Irvine, First 5 Orange County (Children & Families Commission), the County of Orange, the City of Orange, the City of Newport Beach, and the City of Huntington Beach to participate IGT 12; and
3. Authorize the Chief Executive Officer to execute agreements with these entities and their designated providers (as necessary) to seek IGT 12 funds.

Background

The Voluntary Rate Range IGT program allows DHCS and CalOptima Health to secure additional Medi-Cal dollars for eligible Orange County entities. For each IGT transaction, DHCS identifies the estimated member months for rate categories (*e.g.*, adult, adult optional expansion, child, long term care, seniors and persons with disabilities, and whole child model) and provides the total amount available for Orange County to contribute through funding entities. To receive funds, entities provide a dollar amount to DHCS, which is then used to obtain a federal match. DHCS distributes the funds and the match to the eligible entities through CalOptima Health. To date, CalOptima Health has participated in eleven Voluntary Rate Range IGT transactions.

At the inception of the IGT program in 2010-2011, the CalOptima Health Board of Directors (Board) approved retaining 50% of the net proceeds. CalOptima Health retained the flexible funds to support the increase in new CalOptima Health members through additional enhanced benefits as well as contracted Medi-Cal services. In 2022, CalOptima Health reduced the amount of retained funds from 50% of net proceeds to a 2% administrative fee, which allows more funds to funnel to the community through its partners.

Discussion

On August 4, 2023, CalOptima Health received notification from DHCS regarding the IGT 12 opportunity with up to $49.9 million in contributions by entities in Orange County. CalOptima Health's proposal, along with the proposed funding entities' supporting documents, are due to DHCS no later than September 8, 2023.

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The five eligible funding entities (University of California-Irvine, First 5 Orange County, the County of Orange, the City of Orange, and the City of Newport Beach) from the previous IGT transactions were contacted regarding their interest in participation in IGT 12. CalOptima Health also reached out to City of Huntington Beach, as it had recently inquired and expressed interest in IGT. Staff is in the process of developing a strategy to offer additional eligible entities with an opportunity to participate in any future IGT transactions.

The formal DHCS-required letter of interest from the six proposed funding entities was due to CalOptima by August 29, 2023, for submission to DHCS by September 8, 2023.

Board approval is requested to authorize staff to submit the proposal letter to DHCS for participation in IGT 12 and to authorize the Chief Executive Officer to enter into agreements with each of the six proposed funding entities submitting a letter of interest, or their designated providers, for the purpose of securing available IGT funds. Consistent with the most recent IGT transaction, CalOptima Health will retain an administrative fee of 2% of net proceeds, with the remaining net proceeds distributed to the funding entities.

Fiscal Impact
Staff anticipates the recommended action to be net budget neutral to CalOptima Health. The IGT 12 is expected to generate approximately $1.7 million to offset expenses for the administration of the IGT program.

Rationale for Recommendation
Submission of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Calendar Year 2022. It will increase dollars to funding entities in Orange County to support Medi-Cal services to CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Board Action
2. Department of Health Care Services Voluntary Rate Range IGT Program Notification Letter

/s/ Michael Hunn *08/31/2023*
Authorized Signature **Date**

Attachment 1 to the September 7, 2023 Board of Directors Meeting – Agenda Item 16

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
City of Huntington Beach	2000 Main Street	Huntington Beach	CA	92648
City of Newport Beach	100 Civic Center Drive	Newport Beach	CA	92660
City of Orange	300 E. Chapman Avenue	Orange	CA	92866
Children and Families Commission of Orange County (First 5 Orange County)	1505 E 17th Street, Suite 230	Santa Ana	CA	92705
Orange County Health Care Agency	405 W. 5th Street, 7th Floor	Santa Ana	CA	92701
Regents of the University of California, Irvine Medical Center (UCI Health)	333 City Blvd. West, Suite 200	Orange	CA	92868

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CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

August 4, 2023

Nancy Huang
Chief Financial Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: Calendar Year (CY) 2022 (January 1, 2022 – December 31, 2022) Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Ms. Huang:

The Calendar Year 2022 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service period of January 1, 2022, through December 31, 2022.

DHCS shall not direct the MCP's expenditure of payments received under the CY 2022 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

DHCS shall continue to administer all aspects of the IGT related to the CY 2022 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR CALENDAR YEAR 2022:

MCPs should refer to the estimated CY 2022 county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the CY 2022 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. Note that the estimated contribution (Non-Federal Share) amounts are based on CY 2022 capitation rates delivered to plans in July 2023, and actual member months (as of July 2023). Actual amounts may change based on finalized rates and updated enrollment information.

If an MCP elects to participate in the CY 2022 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

Soliciting Interest

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the CY 2022 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:

    1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on MCP letterhead.
    2. The MCP's primary contact information (name, title, e-mail address, mailing address, and phone number).

3. County/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for CY2022. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.
4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the CY 2022 Voluntary Rate Range Program Supplemental Attachment described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.

- The MCP must obtain a **letter of interest** from each governmental funding entity included in the MCP's proposal to DHCS. The highlighted sections in the letter of interest form provided in Attachment A (included below) must be filled out completely and printed on the participating governmental funding entity's letterhead. A separate letter of interest must be provided for each county or rating region. An individual who is authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest.

- The MCP must distribute to governmental funding entities and ensure submission to DHCS, either by the MCP or the governmental funding entity, of the **Calendar Year 2022 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by Friday**, September 8, 2023**.

- The proposals and letters of interest are due to DHCS ***by 5pm on* Friday, *September 8, 2023***. Please send a PDF copy of the required documents by e-mail to Vivian.Beeck@dhcs.ca.gov, Michael.Ha@dhcs.ca.gov, and Scott.Gale@dhcs.ca.gov. ***Failure to submit all required documents by the due date may result in exclusion from the CY 2022 Voluntary Rate Range Program.***

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their uncompensated contracted Medi-Cal costs and/or charges. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the CY 2022 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Vivian Beeck at (916) 345-8271 or by email at Vivian.Beeck@dhcs.ca.gov.

Sincerely,

DocuSigned by:
Michael Jordan
641B9785907E40F...

August 3, 2023

Michael Jordan
Staff Services Manager II
Financial Management Section C
Capitated Rates Development Division

Attachments

cc: Michael Hunn
Chief Executive Officer
CalOptima
505 City Parkway West
Orange, CA 92868

Vivian Beeck
Staff Services Manager I
Financial Management Section C
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

Michael Ha
Health Program Specialist
Financial Management Section C
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

Scott Gale
Associate Governmental Program Analyst
Financial Management Section C
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

ATTACHMENT A – LETTER OF INTEREST

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of _Insert Participating Funding Entity Name, a governmental entity, federal I.D. Number _Insert Federal Tax I.D. Number, in working with Managed Care Plan's Name (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2022 through December 31, 2022. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

_Insert Participating Funding Entity Name is willing to contribute approximately $_____ for the Calendar Year 2022 (January 1, 2022 – December 31, 2022) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:

(Please provide complete information including name, title, street address, e-mail address and phone number.)

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Signature

ATTACHMENT C

TOTAL AVAILABLE RATE RANGE

Voluntary Rate Range Program
Attachment C
January 1, 2022 - December 31, 2022

HPC	Health Plan Name	County	Rate Categories (1)	SIS/ UIS	Total MMs CY 22 (2)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Departmental Usage (3)	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund	Governmental Funding Entity Portion	Non Federal Share %
506	CalOptima	Orange	Child	SIS	3,520,004	83.10	$ 89.70	$ 6.60	$ -	$ 6.60	$ 23,232,027	$ 9,197,710	39.59%
506	CalOptima	Orange	Child	UIS	106,221	67.26	$ 72.61	$ 5.35	$ -	$ 5.35	$ 568,283	$ 443,331	78.01%
506	CalOptima	Orange	Adult	SIS	1,312,319	203.97	$ 217.29	$ 13.32	$ -	$ 13.32	$ 17,480,089	$ 7,515,596	43.00%
506	CalOptima	Orange	Adult	UIS	195,134	503.74	$ 536.63	$ 32.89	$ -	$ 32.89	$ 6,417,957	$ 4,262,295	66.41%
506	CalOptima	Orange	ACA Optional Expansion	SIS	3,556,781	300.55	$ 319.20	$ 18.65	$ 4.66	$ 13.99	$ 49,759,366	$ 4,975,937	10.00%
506	CalOptima	Orange	ACA Optional Expansion	UIS	294,319	743.54	$ 789.68	$ 46.14	$ 11.54	$ 34.60	$ 10,183,438	$ 5,174,422	50.81%
506	CalOptima	Orange	SPD	SIS	435,057	602.70	$ 638.28	$ 35.58	$ -	$ 35.58	$ 15,479,328	$ 6,767,627	43.72%
506	CalOptima	Orange	SPD	UIS	60,061	1,185.97	$ 1,256.00	$ 70.03	$ -	$ 70.03	$ 4,206,072	$ 2,900,629	68.96%
506	CalOptima	Orange	SPD/Full-Dual	SIS	75,272	216.63	$ 227.52	$ 10.89	$ -	$ 10.89	$ 819,712	$ 359,034	43.80%
506	CalOptima	Orange	SPD/Full-Dual	UIS	483	360.28	$ 378.40	$ 18.12	$ -	$ 18.12	$ 8,752	$ 6,442	73.61%
506	CalOptima	Orange	LTC (non-dual)	SIS	11,376	12,922.88	$ 13,273.23	$ 350.35	$ -	$ 350.35	$ 3,985,582	$ 1,745,685	43.80%
506	CalOptima	Orange	LTC (non-dual)	UIS	2,916	12,922.88	$ 13,273.23	$ 350.35	$ -	$ 350.35	$ 1,021,621	$ 934,863	91.51%
506	CalOptima	Orange	LTC/Full-Dual	SIS	-	8,505.92	$ 8,698.00	$ 192.08	$ -	$ 192.08	$ -	$ -	N/A
506	CalOptima	Orange	LTC/Full-Dual	UIS	87	8,505.92	$ 8,698.00	$ 192.08	$ -	$ 192.08	$ 16,711	$ 16,659	99.69%
506	CalOptima	Orange	Whole Child Model	SIS	137,953	1,727.07	$ 1,825.55	$ 98.48	$ -	$ 98.48	$ 13,585,611	$ 5,344,069	39.34%
506	CalOptima	Orange	Whole Child Model	UIS	3,608	1,727.07	$ 1,825.55	$ 98.48	$ -	$ 98.48	$ 355,315	$ 276,459	77.81%
506	**Health Plan Total**	**Health Plan Total**	**All COAs**		**9,711,591**	**281.45**	**$ 298.65**	**$ 17.21**		**$ 15.15**	**$ 147,119,864.00**	**$ 49,920,758**	**33.93%**

Footnotes:
1The supplemental payments (Maternity and BHT) are not included in the rate range calculation.
2 Mainstream Member Months are actuals for CY 22 MM effective as of July 2023.
3 Other Departmental Usages decreases available rate range funding.

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Attachment B

Voluntary Rate Range Program Supplemental Attachment
Calendar Year 2022 (January 1, 2022 through December 31, 2022)

Provider's Legal Name:	
County:	
Health Plan:	

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than September 8, 2023.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2020-21 (July 1, 2020 - June 30, 2021).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other				$ -	$ -
Total	$ -	$ -	$ -	$ -	$ -

* Include payments received and anticipated to be received, for dates of service from July 1, 2020 - June 30, 2021.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2020 - June 30, 2021 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? ***(Yes / No)***

If **No**, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. We ask that a duly authorized representative formally attest to the following÷

(i) The legal name of the entity transferring funds:

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding:

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

(iv) Does the transferring entity have general taxing authority? ***(Yes / No)***

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. ***(Yes / No)***

5. Comments / Notes

Attestation by duly authorized representative:
Please print the Name (first & last), and Title: _____

Signature: _____

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Board of Directors Meeting
February 1, 2024

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

Report to the Board

The Member Advisory Committee (MAC), and the Provider Advisory Committee (PAC) held a regular joint meeting on December 14, 2023, to discuss topics of mutual interest.

Ashley Deemer, O.D., Associate Professor, Ketchum University, presented on Geriatric Vision Issues and noted that there was a growing need for low vision rehabilitation caused by age related eye conditions such as Macular Degeneration, Glaucoma, Diabetic Retinopathy and other Retinal Vascular diseases such as Cataracts. She noted that that the patients had an average age of 77 and 66% were female. Dr. Deemer also presented various case studies and noted that vision deprivation may result in reduced activation in central sensory pathways, which is associated with higher risk of cognitive load and brain structure damage.

Kaycee Velarde, Executive Director, Kaiser Permanente, presented on the transition of Medi-Cal members in CalOptima Health to Kaiser on January 1, 2024. Ms. Velarde answered questions and noted that Kaiser had been working in partnership with CalOptima Health to ensure a smooth transition for those members whose Medi-Cal was administered by CalOptima Health through Kaiser Permanente as a contracted health network.

Yunkyung Kim, Chief Operating Officer, also discussed the Kaiser transition and noted that Kaiser would also attend the Whole-Child Model Family Advisory Committee and discuss the approximately 900 special needs children being impacted by the transition. Ms. Kim thanked the committees for their advice, guidance and support to the CalOptima Health members.

Richard Pitts, D.O., Ph.D., Chief Medical Officer, read a small sampling of the many thank-you letters that CalOptima Health receives from its members. He also thanked Jacob Sweidan, M.D., who is a member of the PAC, for his dedication and participation in CalOptima Health's Credentialing Review Committee, which reviews physicians credentials every fourth Thursday of the month, along with other staff and physicians. Dr. Pitts also thanked the committees for all their assistance to CalOptima Health during 2023.

Michael Hunn, Chief Executive Officer, thanked the MAC and PAC for their help during 2023 and noted that they helped guide the CalOptima Health agenda, both transactionally, as well as programmatically, service-wise right down to the feedback on Workforce Development.

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