NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

NOVEMBER 4, 2021
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

REVISED MATERIALS

BOARD OF DIRECTORS

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

Supervisor Lisa Bartlett, Alternate

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	CLERK OF THE BOARD
Richard Sanchez	Gary Crockett	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, 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 website at www.caloptima.org.

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

1) **Listen to the live audio at or +1 (415) 930-5321 and Access Code: 361-600-647 or**
2) **Participate via Webinar at https://attendee.gotowebinar.com/rt/973201248127155724 rather than attending in person. Webinar instructions are provided below.**

CALL TO ORDER

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS

1. Chief Executive Officer Report
   a. OneCare Four-Star Rating
   b. California Advancing and Innovating Medi-Cal (CalAIM) Preparations
   c. COVID-19 Response Update
   d. CalFresh Educational Presentation
   e. Escape the Vape Event
   f. Delay in Community Health Worker, Doula Care Benefits
   g. PACE Recognition
   h. State Housing Tour
   i. California Association of Health Plans Conference
   j. Media Coverage

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

3. CalAIM Update

PUBLIC COMMENTS

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

CONSENT CALENDAR

4. Minutes
   a. Approve Minutes of the October 7, 2021 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the September 9, 2021 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee and of the September 9, 2021 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

5. Consider Appointment of Member Advisory Committee Vice-Chair

6. Consider Adopting Resolution No. 21-1104-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

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

REPORTS/DISCUSSION ITEMS

ADMINISTRATION

8. Consider Selecting and Contracting with Kennaday Leavitt PC for Outside General Counsel

9. Consider Approval of an Executive Employment Agreement and Agreement Terms for a Temporary (Interim) Chief Executive Officer *(to follow Closed Session)*

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CalAIM)

10. Consider Approval of New Finance Policy FF.4002: Special Payments: Enhanced Care Management Supplemental Payment for Capitated Health Networks

11. Consider Approval of Program Year 1 CalAIM Performance Incentive Payment Methodology for All Health Networks, Except AltaMed Health Services Corporation, Arta Western California, Inc., Monarch Health Plan, Inc., and Talbert Medical Group, P.C.

12. Consider Approval of Program Year 1 CalAIM Performance Incentive Payment Methodology for AltaMed Health Services Corporation

13. Consider Approval of Program Year 1 CalAIM Performance Incentive Payment Methodology for Arta Western California, Inc., Monarch Health Plan, Inc., and Talbert Medical Group, P.C.

14. Consider Authorizing CalOptima Ancillary Services Contract with Whole Person Care and Health Homes Program Providers for the Provision of Community Supports Services

CLINICAL OPERATIONS

15. Consider Authorizing a Contract with GA Food Services LLC for the Diabetes Mellitus Pilot Program's Fresh Produce Delivery Services

NETWORK OPERATIONS

16. Consider Authorizing Amendments for All OneCare Health Network Contracts Except AltaMed Health Services Corporation, ARTA Western California Inc., Monarch Healthcare A Medical Group Inc., and Talbert Medical Group P.C. to Extend the Contracts, Extend the Allocation of Non-Part D CMS Capitation, and Align the Corrective Action Plan Section of the Contracts with Current Policy

17. Consider Authorizing Amendments to the AltaMed Health Services Corporation OneCare Health Network Contract to Extend the Contract, Extend the Allocation of Non-Part D CMS Capitation and Align the Corrective Action Plan Section of the Contract with Current Policy

18. Consider Authorizing Amendments to the OneCare Health Network Contracts for ARTA Western California Inc., Monarch Healthcare, A Medical Group Inc., and Talbert Medical Group P.C. to Extend the Contracts, Extend the Allocation of Non-Part D CMS Capitation and Align the Corrective Action Plan Section of the Contract with Current Policy

19. Consider Authorizing Amendments to Extend the OneCare Connect Cal MediConnect Plan Health Network Contracts for All Health Networks Except AltaMed Health Services Corporation, ARTA Western California Inc., Monarch Health Plan Inc., and Talbert Medical Group P.C., and Align the Corrective Action Plan Section of the Contract with Current Policy

20. Consider Authorizing Amendments to Extend the OneCare Connect Cal MediConnect Plan Health Network Contract for AltaMed Health Services Corporation and Align the Corrective Action Plan Section of the Contract with Current Policy

21. Consider Authorizing Amendments to Extend the OneCare Connect Cal MediConnect Plan Health Network Contracts for ARTA Western California Inc., Monarch Health Plan Inc., and Talbert Medical Group P.C., and Align the Corrective Action Plan Section of the Contract with Current Policy

22. Consider Authorizing Amendment to the OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly Behavioral Health Care Services Contract with the Orange County Health Care Agency

23. Consider Authorizing Extension of Ancillary Fee-for-Service Contracts for Non-Medical Transportation and Disposable Incontinence Supplies Providers

24. Consider Authorizing Amendments to the Kindred Healthcare Fee-for-Service Hospital Contracts to Increase Rates for Medi-Cal Members

ADVISORY COMMITTEE UPDATES

25. Provider Advisory Committee Update

26. Member Advisory Committee Update

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

CS-1 Pursuant to Government Code section 54957, PUBLIC EMPLOYEE APPOINTMENT (Chief Executive Officer)

CS-2 Pursuant to Government Code section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer)

ADJOURNMENT

How to Join

1. Please register for Regular Meeting of the CalOptima Board of Directors on November 4, 2021, 2:00 PM PDT at: **https://attendee.gotowebinar.com/rt/973201248127155724**

2. After registering, you will **receive a confirmation email containing a link to join** the webinar at the specified time and date.

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

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

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

   TO USE YOUR COMPUTER'S AUDIO:

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

   --OR--

   TO USE YOUR TELEPHONE:

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

   United States: +1 (415) 930-5321

   Access Code: 361-600-647

   Audio PIN: Shown after joining the webinar

MEMORANDUM

DATE:	October 28, 2021
TO:	CalOptima Board of Directors
FROM:	Richard Sanchez, Chief Executive Officer
SUBJECT:	CEO Report — November 4, 2021, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

a. **CalOptima OneCare (HMO SNP) Plan Earns Four-Star Rating**

The Centers for Medicare & Medicaid Services (CMS) released the 2022 Star Ratings in early October, awarding OneCare 4 stars overall — 3.5 stars for Part C and 4.5 stars for Part D (pharmacy). A rating of 4 stars is considered "above average" performance by CMS. The 2022 rating is an increase from the 3.5 stars overall OneCare received for 2021. While CalOptima is pleased with the increased rating, staff continues to pursue ways to improve quality care for members. Star ratings are available on www.medicare.gov, and consumers may use them to compare plans.

b. California Advancing and Innovating Medi-Cal (CalAIM) Preparations Continue

In October, preparations intensified for CalAIM's launch on January 1, 2022. Enhanced Care Management (ECM) and Community Supports will be the first benefits to roll out in what is a five-year effort to strengthen and streamline the Medi-Cal program statewide. Stakeholder engagement continued this month, as smaller workgroups that first met at the prior meeting on September 22 are furthering their discussions by meeting weekly about enhancements to the referral processes, coordination, data sharing and more. The broader group will come together again for a check-in and additional collaboration in November. Site visits are being planned for November to engage providers of Community Supports, with the goal of identifying the best use of potential incentive funding to address service capacity and gaps. Readiness assessments of ECM and Community Supports providers are in progress. Clinical policies and contracts will be presented for your Board's consideration in December.

c. CalOptima Works on Incentive Plan Deliverables, Receives Honor for COVID-19 Communications

As of October 27, CalOptima has 418,948 vaccinated members, which is 63% of members age 16 and older and 62% of members age 12 and older. To drive those rates even higher, staff is focused on implementation of CalOptima's efforts related to the state vaccine incentive program. A range of activities are underway, including outreach to populations of focus, provider engagement and a broad advertising campaign. The state is emphasizing accountability for results by requiring submission of outcomes data at three intervals along the way to the program's end in February 2022. In the meantime, CalOptima's communications efforts were honored this month in the Orange County Chapter of the Public Relations Society of America's

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PROTOS Awards. Our comprehensive COVID-19 prevention and vaccination campaigns that included advertising, social media, communications outreach and more received an Award of Excellence in the category of COVID-19 Response Crisis Communications/Issues Management Programs.

d. CalFresh Educational Presentation Draws Large Community Audience

To address social determinants of health and raise awareness about supportive programs available for CalOptima members, CalOptima collaborated with the County of Orange Social Services Agency (SSA) to host two virtual information sessions on the CalFresh program on October 27 and 28. More than 300 attended, representing a variety of member advocate, community and provider organizations. In a separate initiative, details are being finalized so SSA can share data that will assist CalOptima in determining the number of members likely eligible but not enrolled in CalFresh. CalOptima will use the data for targeted outreach.

e. Great American Smokeout Event Centers on Anti-Vaping Messages, Activities

On November 18, CalOptima will partner with local community-based organizations, county agencies and school districts to host CalOptima's annual Escape the Vape, A Great American Smokeout event at Ponderosa Park Family Resource Center in Anaheim. Students age 5–18 throughout Orange County are invited to participate in group activities centered around anti-vaping and anti-smoking, which include scavenger hunt activities to collect cigarette butts on the grounds of the park. The event will also include parent presentations to increase awareness of vaping and current vaping devices. This year, Anaheim Mayor Harry Sidhu will join the opening ceremonies, and media coverage will be provided by PBS and American Cancer Society.

f. New Medi-Cal Benefits for Community Health Workers, Doula Care Delayed

The Enacted State Budget for Fiscal Year 2021–22 added two new Medi-Cal covered benefits: community health worker services and doula care. However, the Department of Health Care Services (DHCS) recently announced a delay in implementation of these new benefits from January 1, 2022, to July 1, 2022. The delay will allow additional time for DHCS to work with stakeholders and health plans, review their input and incorporate it into the State Plan Amendment, and ensure successful system updates. Once that is complete, DHCS will seek federal approval from CMS and provide time for health plans to prepare to offer these services.

g. PACE Garners Continued Recognition by Elected Officials

This month, CalOptima received an Assembly Resolution from Assemblywoman Cottie Petrie-Norris recognizing the PACE program's contributions to Orange County seniors over the past eight years. She also recently toured CalOptima PACE during National PACE Month in September. Staff will display the resolution at the center. And on October 8, U.S. Rep. Mike Levin's lead district representative Terry VanHorne toured CalOptima PACE. Ms. VanHorne was particularly interested in PACE eligibility, transportation and the use of Alternative Care Settings to expand access.

h. State Housing Tour Mentions CalOptima Support

Assemblywoman Sharon Quirk-Silva hosted an invite-only Fall 2021 State Housing Tour. The program began with a panel discussion on housing and homeless services in Southern California. The guests, which included many elected officials, were then invited to tour the Fullerton

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Navigation and Recuperative Care Center, Be Well OC and Buena Esperanza, a Jamboree Housing HomeKey Site. CalOptima was commended during the Fullerton Navigation Center and Be Well OC tours for the agency's ongoing support and collaboration.

i. California Association of Health Plans (CAHP) Conference Addresses Priority Areas

On October 11–13, CalOptima leaders attended the 2021 CAHP Annual Conference. CalOptima's state trade association, CAHP represents all public and commercial health plans in California. I was asked to moderate a CalAIM panel discussing implementation of the ECM and Community Supports benefits. Other conference sessions focused on major health plan priorities, including:

- Improving telehealth access and utilization through various modalities, such as new video technology and e-consults between primary care providers and specialists.
- Increasing access to school-based behavioral health (BH) services through a $400 million Medi-Cal managed care plan (MCP) incentive program to expand BH infrastructure, workforces and partnerships with school districts.
- Coordinating housing and health care services for individuals experiencing homelessness, including a new $650 million Medi-Cal MCP incentive program to enhance homeless health initiatives.
- Addressing health equity and social determinants of health, particularly in response to health disparities during the COVID-19 pandemic.

j. Media Coverage Highlights CalOptima Expertise, Leadership

This month, CalOptima received coverage on three high-profile online sites:

- On October 13, Insider.com ran a story about Halloween safety that included helpful tips from CalOptima Medical Director Thanh-Tam Nguyen, M.D., a pediatrician serving members in the Whole Child Model program.
- On October 15, StateofReform.com covered CalOptima's text campaign to boost vaccination rates, highlighting the innovation and impact of the effort. Director of Population Health Management Pshyra Jones, MPH, was interviewed.
- On October 22, Becker's Payer Issues released a podcast interview with me about CalOptima's pandemic response and work on key initiatives. The interview was recorded in August but released this month.

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COVID-19 Update

Board of Directors Meeting November 4, 2021

Emily Fonda, M.D., MMM, CHCQM
Chief Medical Officer

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CMO Update: Recent Accomplishments

PACE Recognition

- CalOptima received an Assembly Resolution from Assemblywoman Cottie Petrie-Norris recognizing the PACE program's contributions to Orange County seniors over the past eight years. The Assemblywoman and her staff toured the center during National PACE Month in September.

CMS Audit

- On October 21, 2021, CMS issued the draft audit report for CalOptima's OneCare and OneCare Connect programs. The total audit score is 0.59, which when compared with CMS' prior published audit scores from 2018 and 2019, would put CalOptima roughly among the top 25% of performers across 52 plans.

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Latest Data as of 10/22/21

Membership and COVID-19 Case

- CalOptima has **862,079** members (679,415 age 12 and older)
- **5.5%** members tested positive for COVID-19 (0.2% expired)

COVID-19 Vaccination

- **418,947** members are vaccinated
- **387,000** members are eligible for incentives
- **63%** members 16 years and older received at least one dose of vaccine
- **62%** members 12 years and older received at least one dose of vaccine

Vaccine Incentives

- More than **273,727** gift cards processed for general members
- **1,649** gift cards distributed to members experiencing homelessness

Covid Case Source: CalOptima Claims & Encounters | Vaccine Source: CalOptima Claims & Encounters, CAIR2, CAIRs, CMS, DHCS, HN Submissions

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Latest Data as of 10/22/21 (cont.)

Whole-Child Model

- Vaccination rate: **~59%**

Age 65 and Older

Overall vaccination rate**: ~77%**

- LTC members vaccination rate: **~97%**
- PACE participants vaccination rate: **~99%**

By Cities

- Vaccination rates highest in Irvine, Garden Grove and Westminster: **~67-73%**

By Ethnicity

- Highest: Asian population **79%** vaccinated (statewide Medi-Cal* 73.1%)
- Lowest: Black population **45%** vaccinated (statewide Medi-Cal* 39.1%)

Covid Case Source: CalOptima Claims & Encounters | Vaccine Source: CalOptima Claims & Encounters, CAIR2, CAIRs, CMS, DHCS, HN Submissions | *DHCS data as of 10/4

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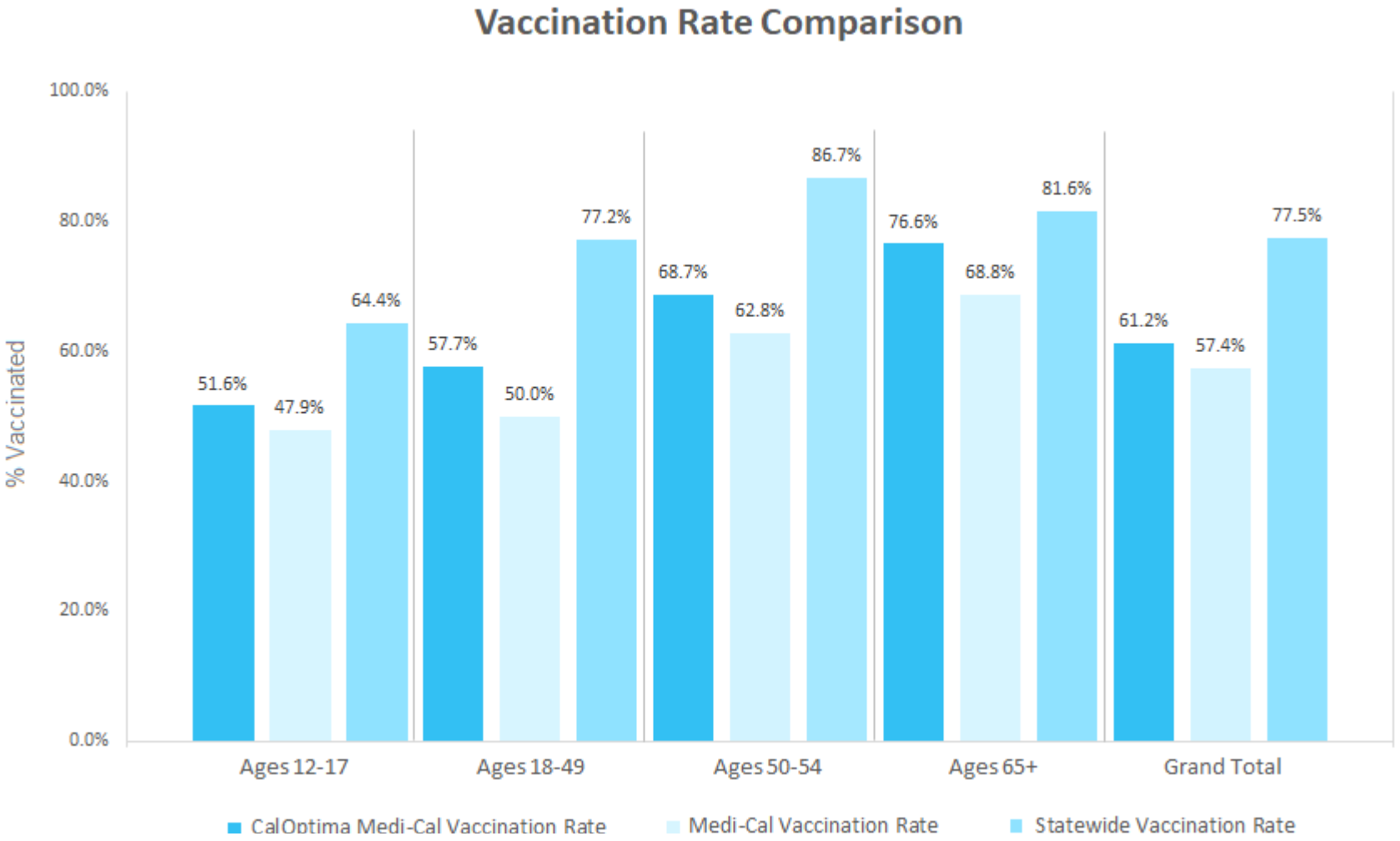
Vaccination Rate Comparison*



*DHCS data as of 10/4/21; CalOptima data as of 10/22/21

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Booster Shots

- FDA authorization of a booster dose:
  - Pfizer (9/22/21)
  - Moderna and Johnson & Johnson (10/20/21)
- Who should be getting a booster shot?
  - 65 years and older with chronic conditions
  - 18 years and older who live in long-term care settings, have underlying medical conditions, or work/live in high-risk settings
- Who should not receive a booster?
  - People with an immediate allergic reaction to a vaccine ingredient or after getting the first dose
- More details are available on CDC and FDA websites

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Addressing Vaccine Hesitancy

- Carenet has scheduled 4,476 appointments after 132,605 outreach phone calls
- Specifics about vaccine reluctance (per Carenet):
  - Fear due to pre-existing health concerns
  - No trust in government agencies (e.g., FDA)
  - Misinformation about deaths following vaccinations
  - Concerns about long-term vaccine effects
  - Freedom of choice/political views
- CalOptima continues to utilize trusted messenger videos, texting and social media campaigns to counter inaccurate information and vaccine hesitancy

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Continuing Outreach Efforts

- Flu vaccination
  - Annual flu awareness and prevention postcard – OneCare and OneCare Connect members
  - Mobile texting campaign – Medi-Cal members
- COVID-19 vaccination
  - Mobile texting campaign focused on COVID-19 boosters targeted to any fully vaccinated members
  - As part of Vaccination Incentive Program, current activities to improve rates among the unvaccinated include: targeted messages to the lowest performing ethnicities and digital/radio/TV ads
- Infomercials to be aired on PBS to emphasize flu and COVID-19 vaccine importance

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Our Mission

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

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California Advancing and Innovating Medi-Cal (CalAIM) Update

Board of Directors Meeting

November 4, 2021

Yunkyung Kim

Chief Operating Officer

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CalAIM Overview

- CalAIM is a multiyear initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes for vulnerable populations
- CalAIM has three primary goals:
  - Identify and manage member risk by using whole person care approaches and addressing Social Determinants of Health
  - Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility
  - Improve quality outcomes, reduce health disparities and drive delivery system transformation

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Enhanced Care Management (ECM)

- ECM builds upon CalOptima's Health Homes Program and responsibility for members' physical health
  - Starting January 1, 2022, CalOptima and health networks will provide ECM services for members who are eligible and enroll
  - Delivery model of ECM services is expected to evolve
- DHCS set the statewide ECM Populations of Focus timeline

January 1, 2022
- Individuals and families experiencing homelessness
- Adult high utilizers
- Adults with Serious Mental Illness (SMI) and Substance Use Disorder (SUD)

January 1, 2023
- Members eligible for Long-Term Care and at risk for institutionalization
- Nursing home residents transitioning to the community
- Individuals (adults and children/youth) transitioning from incarceration

July 1, 2023

Children and youth with special conditions:
- High utilizers
- Serious Emotional Disturbance (SED) or identified to be at Clinical High Risk (CHR) for Psychosis or experiencing a first episode of Psychosis
- Enrolled in California Children's Services (CCS)/CCS Whole-Child Model with additional needs beyond the CCS qualifying condition
- Involved in, or with a history of involvement in, child welfare (including foster care up to age 26)

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Community Supports

- Four Community Supports to launch January 1, 2022
  - Same services as Orange County's Whole Person Care Pilot
- Future Community Supports will be considered with community input
  - Can be implemented every six months, starting from January 1, 2022, upon notice and submission of an updated CalAIM Model of Care to DHCS

Community Supports
☑ Housing transition navigation services
☑ Housing deposits
☑ Housing tenancy and sustaining services
☑ Recuperative care (medical respite)
☐ Medically supportive food/meals/medically tailored meals
☐ Short-term post-hospitalization housing
☐ Personal care and homemaker services
☐ Respite services
☐ Day habilitation programs
☐ Nursing facility transition/diversion to assisted living facilities
☐ Community transition services/nursing facility transition to a home
☐ Environmental accessibility adaptations (home modifications)
☐ Asthma remediation
☐ Sobering centers

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Implementation Activities

DHCS Deliverables

Approved
- Model of Care Part 1
- ECM contract template
- Community Supports contract template

In Review
- Model of Care Parts 2 and 3

Stakeholder Activities

Completed
- Community stakeholder event
- Community referral process and form
- Community Supports authorization process

In Progress
- CalOptima Connect to support data sharing:
  - Member eligibility
  - Clinical and Social Services information
  - Billing information

Operational Readiness

On Target for Launch
- ECM and Community Supports readiness assessment
- Clinical and finance policies
- Contract execution:
  - Health Network ECM services
  - Community Supports provider services
  - County ECM SMI/SUD services

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What's Next

- Launch on January 1, 2022
- Present a five-year roadmap to your Board in Q1 2022
- Continue to evaluate program and adjust as needed

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Our Mission

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

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

October 7, 2021

A Regular Meeting of the CalOptima Board of Directors was held on October 7, 2021, at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and of Assembly Bill (AB) 361 (Chaptered September 16, 2021), which allows for temporary relaxation of certain Brown Act requirements related to teleconferenced meetings. Chairman Andrew Do called the meeting to order at 2:01 p.m. and Vice Chair Clayton Corwin led the Pledge of Allegiance.

ROLL CALL

Members Present: Supervisor Andrew Do, Chairman; Clayton Corwin, Vice Chair; Isabel Becerra; Supervisor Doug Chaffee; Clayton Chau, M.D. (non-voting); Scott Schoeffel; Nancy Shivers; Trieu Tran, M.D.
(All Board Member attendees participated remotely except Chairman Do and Vice Chair Corwin, who attended in person)

Members Absent: Mary Giammona, M.D

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

PRESENTATIONS/INTRODUCTIONS

Chairman Do and Richard Sanchez, Chief Executive Officer, welcomed Yunkyung Kim who joining CalOptima on October 1, 2021, as Chief Operating Officer. Mr. Sanchez also congratulated the Clerk of the Board Sharon Dwiers for reaching 25 years of service at CalOptima.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Richard Sanchez, Chief Executive Officer, highlighted several items from his report, including CalOptima receiving the National Committee for Quality Assurance recognition as one of the top rated Medi-Cal plans in California for the seventh year in a row, with a rating of four out of five possible stars. Mr. Sanchez also noted that CalOptima received an Award of Excellence from the Public Relations Society of America for its texting campaign which is part of CalOptima's vaccination efforts.

2. Chief Medical Officer Updates

Emily Fonda, M.D., Chief Medical Officer, provided an update on CalOptima's membership and COVID-19 vaccination efforts. Dr. Fonda noted that CalOptima's membership continues to grow and as of September 24, 2021, there are almost 856,000 members, and of those, 409,007 members are vaccinated. Dr. Fonda also mentioned that the vaccination rates for members aged 16 years and over is at 63% and for those aged 12 years and over, the vaccination rate remains at 61%. Dr. Fonda also provided an update on the Department of Health Care Services' (DHCS) Vaccine Incentive Plan.

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PUBLIC COMMENTS

1. Victor Mendez, CalOptima Member re: Oral re: Receiving referrals from his provider office.

CONSENT CALENDAR

3. Minutes
   a. Approve Minutes of the September 2, 2021 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the May 19, 2021 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee; the Minutes of the May 20, 2021 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; the Minutes of the April 27, 2021 Regular Meeting of the CalOptima Board of Directors' Whole Child Model Family Advisory Committee; the Minutes of the June 24, 2021 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee; the Minutes of the August 12, 2021 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee; the Minutes of the August 12, 2021 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

4. Consider Approval to Extend the Behavioral Health Applied Behavior Analysis Pay for Value Performance Program for Calendar Year 2022

5. Consider Accepting and Receiving and Filing Fiscal Year 2020-21 CalOptima Audited Financial Statements

6. Consider Adopting Resolution No. 21-1007-01, Authorizing the Execution of Contract MS-21-22-41 with the California Department of Aging in order to Continue Operation of the Multipurpose Senior Services Program

7. Consider Approval of Modifications to CalOptima PACE Policy PA.1002 Mandatory Medical Equipment and Supply Requirements

8. Consider Authorizing and Directing Execution of Amendments to CalOptima's Primary and Secondary Agreements with the California Department of Health Care Services

9. Consider Authorizing Execution of an Amendment(s) to CalOptima's Primary Medi-Cal Agreement with the Department of Health Care Services Related to Enhanced Care Management, In Lieu of Services, and Additional Covered Aid Codes

10. Consider Appointment of Whole-Child Model Family Advisory Committee Vice Chair

11. Receive and File:
   a. August 2021 Financial Summary
   b. Compliance Report
   c. Federal and State Legislative Advocates Reports

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d. CalOptima Community Outreach and Program Summary

Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors approved Consent Calendar as presented. (Motion carried 7-0-0; Director Giammona absent)***

REPORTS/DISCUSSION ITEMS

ADMINISTRATIVE

12. Consider Authorizing Contract with Health Management Associates for Consulting Services to Assist in Preparation for the Department of Health Care Services Routine Medical Audit Scheduled for January 2022, and Authorize Expenditures from Existing Reserves for Such Services

Action: ***On motion of Director Shivers seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute a contract with HMA for consulting services to prepare for the Department of Health Care Services (DHCS) medical audit, and assist with addressing subsequent findings and corrective actions, as necessary; and 2.) Authorized unbudgeted expenditures in an amount up to $250,000 from existing reserves to fund this contract through June 30, 2022. (Motion carried 7-0-0; Director Giammona absent)***

13. Consider Ratifying Salary Schedule Adopted on September 2, 2021, and Actions to Amend the Chief Executive Officer's Employment Agreement and Adjust the Base Salaries of Executive Level Positions to at Least the Minimums of the New Salary Ranges included in Salary Schedule

Prior to the motion and vote by the Board, the Clerk orally read the recommended action into the record.

Action: ***On motion of Chairman Do, seconded and carried, the Board of Directors: Ratified 1.) Approval and Implementation of Salary Schedule Presented to the Board on September 2, 2021, effective September 12, 2021; 2.) Actions to amend the Chief Executive Officer's (CEO) employment agreement to increase his annual base salary to $560,000, the minimum of the salary range for the CEO position; and 3.) Adjustments to the annual base salaries of executive level positions to at least the minimum of the new salary ranges consistent with the attached Salary Schedule in the amounts of $433,000 for the Chief Operating Officer; $368,000 for the Chief Counsel, Chief Financial Officer, and Chief Medical Officer; $313,000 for the Chief Information Officer, Deputy Chief Counsel, and Deputy Chief Medical Officer; and $226,000 for the Chief of Staff and Executive Directors of Behavioral Health Integration, Clinical Operations, Compliance, Finance, Human Resources, Network Operations, Operations, Program Implementation, Public Affairs, and Quality & Population Health Management.***

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(Motion carried 7-0-0; Director Giammona absent)

14.Consider Approval of Program Year 1 CalAIM Performance Incentive Payment Methodology
This item was continued to a future meeting.

15.Consider Authorization of Unbudgeted Expenditures for Various Capital Improvements

Action: ***On motion of Director Shivers, seconded and carried, the Board of Directors: Authorized unbudgeted expenditures and appropriated funds from existing reserves for capital improvements at the 505 City Parkway West building in amounts of up to: 1.) $4,230 to "Upgrade Card Access System;" and 2.) $275,000 for "New Roof Membrane."***
(Motion carried 7-0-0; Director Giammona absent)

16. Consider Authorizing Extension of Contracts Related to CalOptima's Key Operational Systems
Director Schoeffel did not participate in this item due to potential conflicts of interest.

After discussion related to the length of the extensions for various operational system contracts the Board amended the recommended action as follows:

Action: ***On motion of Chairman Do, seconded and carried, the Board of Directors amended the staff recommended motion and authorized the Chief Executive Officer (CEO) to: 1) Extend the contracts with all of the following vendors for 3 years except for vendors c.) Edifecs, Inc. and d.) ImageNet, LLC, whose contracts will be extended for 3.5 years. All of the contract amendments with the referenced vendors will include an additional one year extension option exercisable at the CalOptima Board's discretion. ~~through the dates indicated in the attached Tables 1, 2 and 3:~~ a.) Cognizant TriZetto Software Group, Inc., b.) Catalyst Solutions, LLC, c.) Edifecs, Inc., d.) ImageNet, LLC, e.) LexisNexis Risk Solutions FL Inc, and Enclarity, Inc., f.) Symplr, g.) Change Healthcare Technologies, LLC, h.) Ceridian Corporation, i.) Silk Road Technology, Inc., j.) Varis, LLC, k.) SmartComms, LLC, l.) InfoCrossing, A WIPRO Company, m.) Intuitive Technology Group, Inc., n.) Lumen Technologies; and 2.) Authorized payment of maintenance and support fees to these vendors for the timeframes noted above. ~~through the dates and up to the amounts indicated in the attached Tables 1, 2 and 3.~~***
(Motion carried 6-0-0; Directors Schoeffel and Giammona absent)

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CLINICAL OPERATIONS

17. Consider Authorizing Kaiser Foundation Health Plan, Inc.'s Collaboration in Mutually Identified Quality Initiatives Including Participation in CalOptima's Quality Improvement Committee

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

Action: ***On motion of Director Shivers, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO) to request that Kaiser Foundation Health Plan, Inc. (Kaiser) collaborate with CalOptima on mutually identified quality initiatives through the following: 1.) Participating in CalOptima's Quality Improvement Committee (QIC) on a quarterly basis (minimum); and 2.) Collaboration on areas of focus with sharing of best practices and strategies. This collaboration will occur a minimum of quarterly or more often as needed. The areas of focus include: a.) Poorly Controlled Diabetes, b.) Lead Screening in Children, c.) Prenatal and Postpartum Care, d.) Well Child Visits, e.) Member Experience, f.) COVID-19 Vaccination Response Plan (Motion carried 6-0-0; Directors Schoeffel and Giammona absent)***

18. Consider Approving an Exemption to the Required Submission of the Seniors and Persons with Disabilities (SPD) Tracking Log (Medi-Cal) Report for Kaiser Foundation Health Plan, Inc.

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

Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors: 1.) Approved an exemption for Kaiser Foundation Health Plan, Inc. (Kaiser) to the SPD Tracking Log (Medi-Cal) reporting requirement in Kaiser's Delegation Agreement; and 2.) Approved modification of CalOptima Policy HH.2003 Health Network and Delegated Entity Reporting, removing the SPD Tracking Log (Medi-Cal) from required Kaiser reports. (Motion carried 6-0-0; Directors Schoeffel and Giammona absent)***

PUBLIC AFFAIRS

19.Consider Authorizing Contract and Funding with Miller Geer & Associates for External Communications Support Services

Action: ***On motion of Chairman Do, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute a contract with Miller Geer & Associates, effective August 1, 2021, through June 30, 2022, for external communications support services at a fixed monthly rate of $12,000; and 2.) Authorized unbudgeted expenditures in an amount not to exceed $132,000 from existing reserves to fund the contract through June 30, 2022. (Motion carried 7-0-0; Director Giammona absent)***

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20. Consider Appropriation of Funds and Authorization of Unbudgeted Expenditures and Other Actions as Necessary to Implement the All-Plan Letter (APL) 21-010: Medi-Cal COVID-19 Vaccination Incentive Program

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors; 1.) Authorized appropriation of funds and authorized unbudgeted expenditures in an amount up to $659,000 from existing reserves to implement the All-Plan Letter (APL) 21-010: Medi-Cal COVID-19 Vaccination Incentive Program (DHCS VIP) for CalOptima members; 2.) Authorized unbudgeted expenditures in an amount up to $23,311 from existing reserves to fund a Community Relations Specialist position through December 31, 2021; and 3.) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to execute agreements and take other actions as necessary to implement the DHCS VIP for CalOptima members. (Motion carried 7-0-0; Director Giammona absent)***

ADVISORY COMMITTEE UPDATES

21. OneCare Connect Member Advisory Committee Update
Patty Mouton, OneCare Connect Member Advisory Committee Chair was unable to attend the meeting; however, the Committee update is included in the Board materials.

22. Whole-Child Model Family Advisory Committee Update
Kristen Rogers, Whole-Child Model Family Advisory Committee Chair, provided an update on the WCM's recent and upcoming activities.

23. Provider Advisory Committee Update
Dr. Junie Lazo-Pearson, Provider Advisory Committee (PAC) Chair, provided an update on the PAC's recent and upcoming activities.

24. Member Advisory Committee Update
Christine Tolbert, Member Advisory Committee (MAC) Chair, provided an update on the MAC's recent and upcoming activities.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

None.

CLOSED SESSION

The Board adjourned to closed session at 2:57 p.m. pursuant to Government Code section 54956.9, subdivision (d)(2), Conference with Legal Counsel, Anticipated Litigation (Number of Potential Cases: 1).

The Board of Directors reconvened to open session at 4:13 p.m. with no reportable action taken.

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ADJOURNMENT
Hearing no further business, Chairman Do adjourned the meeting at 4:13 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: November 4, 2021

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MINUTES

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

September 9, 2021

A Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on September 9, 2021, CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

CALL TO ORDER

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

ESTABLISH QUORUM

Members Present:	Christine Tolbert, Chair; Pamela Pimentel, Vice Chair; Maura Byron; Meredith Chillemi; Sandra Finestone; Connie Gonzalez; Jacqueline Gonzalez; Hai Hoang; Sally Molnar; Patty Mouton; Kate Polezhaev; Sister Mary Therese Sweeney; Steve Thronson
Members Absent:	Linda Adair; Melisa Nicholson;
Others Present:	Richard Sanchez, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Emily Fonda, M.D. Chief Medical Officer; Mike Herman, Interim Executive Director, Program Implementation; Albert Cardenas, Director, Customer Service; Cheryl Simmons, Staff to the Advisory Committees; Jorge Dominguez, Lead Customer Service Representative, Customer Service; Brenda Alvarez-Nieves, Program Assistant, Customer Service

MINUTES

Approve the Minutes of the August 12, 2021 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

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

PUBLIC COMMENT

There were no public comments

CEO AND MANAGEMENT REPORTS

Chief Operating Officer Report

Ladan Khamseh, Chief Operating Officer, provided an update on Qualified Medical Beneficiary outreach and noted that over 1,500 members had been identified who could possibly qualify to

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receive Medicare Part A and B. She also noted that a notification mailing would be sent to approximately 1,000 members in November with follow up phone outreaches afterwards. Ms. Khamseh also discussed how CalOptima is completing submission of further documentation in response to Centers for Medicare and Medicaid Services (CMS) requests as part of the recent audit. It is expected that CMS will provide a draft final report in October and CalOptima will have 10 days to respond to any concerns raised before CMS issues their final report.

Chief Medical Officer Report
Emily Fonda, M.D. Chief Medical Officer, informed the committee that CalOptima scored one hundred percent on the NCQA accreditation audit, placing CalOptima as one of the top-ranking managed care plans in the State of California. Dr. Fonda updated the MAC on the vaccine status in Orange County and distribution of the vaccine gift cards for CalOptima members.

INFORMATION ITEMS

MAC Member Updates
Chair Christine Tolbert reminded the members that they should have received an email regarding their yearly compliance courses that were due at the beginning of November. She asked the members to reach out to Cheryl Simmons for assistance if they had difficulties accessing these compliance courses.

California Advancing and Innovating Medi-Cal (CalAIM) Update
Mike Herman, Interim Executive Director, Program Implemented presented an update on the CalAIM program noting that the program was scheduled to start on January 1, 2022 with rollout to a certain population of Medi-Cal members. Mr. Herman reviewed the timeline for the program's full implementation detailing what will happen each month leading up to January 1, 2022.

At this time, Chair Christine Tolbert rearranged the agenda to hear item V.A Chief Executive Officer Report before continuing with the agenda.

Chief Executive Officer Report
Richard Sanchez, Chief Executive Officer, thanked the CalOptima staff for their work on ensuring that all submissions to the Department of Health Care Services (DHCS) on the CalAIM program were submitted timely. Mr. Sanchez also answered a question on an item of interest from his August report regarding Governor Newsom's Children and Youth Behavioral Health Initiative, that was included in the Fiscal Year 2021–22 Enacted Budget. This initiative allows Medi-Cal plans to receive incentive payments to expand access to school-based behavioral health services. He noted that CalOptima has reached out to Orange County school districts regarding this new initiative.

Families Together of Orange County
Omar Moreno, Chief Operating Officer of Families Together Orange County provided a verbal update along with a video on how Families Together has been able to assist CalOptima members with COVID testing and vaccines during the pandemic.

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Back-to-School Learning Related Vision Disorders

Jillian Youngerman, O.D. Assistant Professor, Ketchum University, presented on Back to School Learning Related Vision Disorders. Dr. Youngerman emphasized that the American Optometric Association's recommended timeline for eye exams was to start by six to twelve months of age to catch conditions with high refractive error that may cause amblyopia later in life.

ADJOURNMENT

Hearing no further business, Chair Tolbert adjourned the meeting at 4:51 p.m.

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

Approved: October 14, 2021

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MINUTES

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

September 9, 2021

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on September 9, 2021, CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing requirements of the Brown Act.

CALL TO ORDER

PAC Chair Dr. Lazo-Pearson, called the meeting to order at 8:01 a.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Junie Lazo-Pearson, Ph.D., Chair; John Nishimoto, O.D., Vice Chair; Amin Alpesh, M.D.; Anjan Batra, M.D.; Jennifer Birdsall, Ph.D.; Tina Bloomer, MHNP; Donald Bruhns; Gio Corzo; Jena Jensen; Alexander Rossel; Jacob Sweidan, M.D.; Loc Tran, PharmD.; Christy Ward

Members Absent: Andrew Inglis, M.D.

Others Present: Richard Sanchez, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Gary Crockett, Chief Counsel; Emily Fonda, M.D., Chief Medical Officer; Michelle Laughlin, Executive Director, Network Operations; Mike Herman, Interim Executive Director, Program Implementation; Cheryl Simmons, Staff to the Advisory Committees; Jorge Dominguez, Lead Customer Service Representative, Customer Service; Brenda Nieves Alvarez, Program Assistant, Customer Services

MINUTES

Approve the Minutes of the August 12, 2021 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Dr. Amin, seconded and carried, the Committee approved the minutes of the August 12, 2021 regular meeting. (Motion carried 13-0-0; Member Dr. Inglis absent)***

PUBLIC COMMENTS

There were no public comments.

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CEO AND MANAGEMENT REPORTS

Chief Executive Officer Report

Richard Sanchez, Chief Executive Officer, updated the committee on the CalAIM and vaccine initiatives and thanked the CalOptima staff for their hard work in these endeavors. He referred the members to his CEO Report that was included in their meeting materials for more information.

Chief Operating Officer Report

Ladan Khamseh, Chief Operating Officer, provided an update on Qualified Medical Beneficiary outreach and noted that over 1,500 members had been identified who could possibly qualify to receive Medicare Part A and B. She also noted that a notification mailing would be sent to approximately 1,000 members in November with follow up phone outreaches afterwards. Ms. Khamseh also discussed how CalOptima is finalizing the submission of further documentation in response to the Centers for Medicare and Medicaid Services (CMS) requests as part of the audit. It is expected that CMS will provide a draft final report in October and CalOptima will have 10 days to respond to any concerns raised. Subsequent to that CMS will issue their final report.

Chief Medical Officer Report

Emily Fonda, M.D., Chief Medical Officer, provided a comprehensive COVID-19 update and updated the PAC on the vaccine status in Orange County and distribution of the vaccine gift cards for CalOptima members.

INFORMATION ITEMS

California Advancing and Innovating Medi-Cal (CalAIM) Update

Mike Herman, Interim Executive Director, Program Implementation, presented an update on the CalAIM program noting that the program was scheduled to start on January 1, 2022 with rollout to a certain population of Medi-Cal members. Mr. Herman reviewed the timeline for the program's full implementation and detailed what will happen each month leading up to January 1, 2022.

Did Telehealth After the COVID Pandemic Equate to Increased Efficiency and Patient Satisfaction?

Anjan Batra, MD, MBA, Director of Electrophysiology, CHOC, Professor of Pediatrics, UC Irvine, and Physician Representative on the PAC, presented on how telehealth during the COVID Pandemic has increased efficiency and patient satisfaction. Dr. Batra noted that the consensus was that telehealth equated to increased efficiency and improved patient satisfaction, that telehealth was here to stay and providers should continue to improve these platforms that make it more convenient for the patients to receive health care.

OneCare Connect Transition

Ravina Hui, Director, Program Implementation updated the PAC on the Centers for Medicare and Medicaid Services (CMS) transition of the Cal MediConnect program, currently known as CalOptima's OneCare Connect program. She noted that the program would conclude on

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December 31, 2022. Ms. Hui also noted that existing OneCare Connect members would have the option of being moved to CalOptima's OneCare program for 2023.

Community Relations Update

Tiffany Kaaiakamanu, Manager, Community Relations presented on how Community Relations has transitioned their outreach and education efforts in the community during the COVID-19 pandemic. She noted that approximately 41 community events/resource fairs had to be cancelled or postponed between March and May 2020. She also noted that since March 2020, the Community Relations Department had been following local, state and federal guidelines to slow the spread of COVID. Ms. Kaaiakamanu noted that Community Relations continued to support the community by attending virtual meetings on a regular basis, provided CalOptima Medi-Cal presentations and hosted virtual events for community partners and their staff, such as the Community Alliances Forum, Cafecito's and the Virtual Resource Fair.

PAC Member Updates

Chair Dr. Lazo-Pearson reminded the members that a there was still a Physician Representative opening to fulfill an existing term through June 30, 2022. Dr. Lazo-Pearson also reminded the members that they should have received their email on how to access the yearly compliance courses and noted that they would be due in early November. She asked the members to reach out to Cheryl Simmons should they have difficulty accessing their courses.

ADJOURNMENT

Chair Dr. Lazo-Pearson reminded the PAC that the next meeting would be on October 14, 2021 at 8 a.m. Hearing no further business, Dr. Lazo-Pearson adjourned the meeting at 9:37 a.m.

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

Approved: October 14, 2021

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CalOptima Board Action Agenda Referral

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Consider Appointment of Member Advisory Committee Vice Chair

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Ladan Khamseh, Executive Director, Operations, (714) 246-8866

Recommended Action

The Member Advisory Committee (MAC) recommends the appointment of Maura Byron as the MAC Vice Chair for a term ending June 30, 2022.

Background

The CalOptima Board of Directors established the MAC by resolution on February 14, 1995, to provide input to the Board on behalf of CalOptima's members and stakeholders. The MAC is comprised of fifteen voting members. Most MAC members serve two-year terms, except for the two standing seats — representatives from the Orange County Social Services Agency and the Orange County Health Care Agency — which have unlimited terms. The CalOptima Board is responsible for the appointment of all MAC members, including the Chair and Vice Chair.

Pursuant to Resolution Nos. 16-0804 and 20-0806, the CalOptima Board of Directors is responsible for the appointment of the MAC Chair and Vice Chair from among appointed members. The Chair and Vice Chair may serve two-year terms.

Discussion

In the month leading up to the October 14, 2021, MAC meeting, committee members were asked to submit letters of interest for the Vice Chair position to the Advisory Committees' staff. MAC members Maura Byron and Hai Hoang submitted letters of interest for the Vice Chair position that was left vacant by the resignation of Pamela Pimentel from both the Vice Chair position and her committee seat on September 21, 2021. At their October 14, 2021, meeting, MAC members voted to recommend Maura Byron as the Vice Chair to fulfill the remaining term left vacant by the resignation of Ms. Pimentel.

MAC Vice Chair Candidates

Maura A. Byron, MEd

Ms. Byron is the Executive Director of the Family Support Network. As the executive director, she assists families of children with complex health care needs to maneuver the special needs system and secure services. In addition, she responds to families' questions and provides peer and emotional support. She has been a member of the MAC since 2020, holding the Family Support seat. Ms. Byron has also served as a member of CalOptima's Whole-Child Model Family Advisory Committee since 2018, holding a Community Based Organization seat. Ms. Byron previously served a two-year term as the Chair of the WCM FAC during the time she held an Authorized Family Representative seat.

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

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Open nominations were held at the October 14, 2021, MAC meeting based on the letters of interest received. During the meeting, there were no additional nominations made from the floor. The MAC forwards the recommended Vice Chair candidate to the Board of Directors for consideration and appointment.

Concurrence
Member Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Sanchez — *10/28/2021*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

6. Consider Adopting Resolution No. 21-1104-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

Contact

Richard Sanchez, Chief Executive Officer, (657) 900-1481

Recommended Action

Adopt Board Resolution No. 21-1104-01, authorizing remote teleconference meetings for the CalOptima Board of Directors and its advisory committees in accordance with Government Code section 54953, subdivision (e).

Background

Under the Ralph M. Brown Act, California Government Code Section 54950 *et seq.*, ("Brown Act") meetings of California local public bodies must be open and public. Prior to the COVID-19 pandemic, the Brown Act has generally allowed a local agency to use teleconferencing for public meetings, subject to specific agenda, posting, physical access, and quorum requirements. On March 4, 2020, pursuant to Government Code section 8625, Governor Gavin Newsom declared a state of emergency related to the COVID-19 pandemic, and the declaration of emergency continues in effect and has not been lifted or rescinded. On March 17, 2020, Governor Newsom signed Executive Order N-29-20, suspending certain provisions of the Brown Act, including, in part, suspending the requirement for in-person legislative meetings and suspending the requirement that each teleconference location be accessible to the public. The Governor's Executive Order expired on September 30, 2021.

Under Assembly Bill (AB) 361, which was signed by Governor Newsom and took effect on September 16, 2021, the Brown Act was amended for a limited time to authorize local agencies to hold teleconference public meetings without complying with certain Brown Act requirements provided that certain conditions are met. These include:

> (A) The legislative body holds a meeting during a proclaimed state of emergency, and state or local officials have imposed or recommended measures to promote social distancing; or
>
> (B) The legislative body holds a meeting during a proclaimed state of emergency for the purpose of determining, by majority vote, whether as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees; or
>
> (C) The legislative body holds a meeting during a proclaimed state of emergency and has determined, by majority vote, pursuant to subparagraph (B), that, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

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If meetings are held via teleconference under these special circumstances, the legislative body must ensure that notice of the meetings are given and agendas posted, and that the rights of the public to observe and participate are protected (including delaying action on any items during any period where a disruption prevents the broadcasting of the meeting to the public and or the ability of the public to participate).

Discussion

Pursuant to the language of AB 361, in order for CalOptima to continue holding teleconference meetings, the Board is required to make the following findings by majority vote within 30 days of teleconferencing for the first time under AB 361 and every 30 days thereafter:

> (A) The legislative body has reconsidered the circumstances of the state of emergency.
> (B) Any of the following circumstances exist:
> (i) The state of emergency continues to directly impact the ability of the members to meet safely in person; or
> (ii) State or local officials continue to impose or recommend measures to promote social distancing.

Given the continued active declaration of emergency arising from the COVID-19 pandemic, there is an ongoing need for holding teleconference meetings for the CalOptima Board of Directors and its advisory committees. In addition, the County of Orange Health Officer issued "Orders and Strong Recommendations," updated as of October 12, 2021, to strongly recommend preventative measures such as avoiding gathering and practicing social distancing. For CalOptima to continue the teleconference meetings, the required finding are set forth in the attached Resolution No. 21-1104-01.

In addition, as part of the continued obligations to protect the public's right to participate in the meetings of local legislative bodies, CalOptima is also required to do the following:

- Allow the public to access the meeting and require that the agenda provide an opportunity for the public to directly address the legislative body pursuant to the Brown Act's other teleconferencing provisions.
- In each instance when CalOptima provides notice of the teleconferenced meeting or post its agenda, give notice for how the public can access the meeting and provide public comment.
- Identify and include in the agenda an opportunity for all persons to attend via a call-in or an internet-based service option.
- Conduct teleconference meetings in a manner that protects the statutory and constitutional rights of the public.
- In the event of service disruption that either presents CalOptima from broadcasting the meeting to the public using the call-in or internet-based service option or a disruption within CalOptima's control that prevents the public from submitting public comments, stop the meeting until public access is restored.
- Not require comments be submitted in advance and provide the opportunity to comment in real time.

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- Provide adequate time for public comment, either by establishing a timed public comment period or by allowing a reasonable amount of time to comment, including the time that may be required for an individual to register to log in to the teleconference to provide public comment.

Fiscal Impact
The recommended action to adopt a resolution authorizing remote teleconference meetings for the CalOptima Board of Directors and its advisory committees in accordance with Government Code section 54953, subdivision (e), will have no fiscal impact on CalOptima.

Rationale for Recommendation
The recommended action to allow for teleconference meetings for the CalOptima Board of Directors and its advisory committees will satisfy the requirements of Government Code section 54953, subdivision (e) and allow CalOptima to hold public meetings via teleconference as the statute allows in a manner that will minimize the risks associated with the continuing public emergency related to the COVID-19 pandemic.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Board Resolution No. 21-1104-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with Government Code section 54953, subdivision (e)
2. March 4, 2020, Proclamation of a State of Emergency
3. October 12, 2021, Orange County Health Officer's Orders and Strong Recommendations
4. Government Code section 54953, as amended by AB 361

/s/ Richard Sanchez *10/28/2021*
Authorized Signature **Date**

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RESOLUTION NO. 21-1104-01

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

AUTHORIZING REMOTE TELECONFERENCE MEETINGS FOR THE CALOPTIMA BOARD OF DIRECTORS AND ITS ADVISORY COMMITTEES IN ACCORDANCE WITH GOVERNMENT CODE SECTION 54953, SUBDIVISION (e)

WHEREAS, CalOptima is a local public agency created pursuant to Welfare and Institutions Code section 14087.54 by the County of Orange under Orange County Ordinance No. 3896, as amended, which established CalOptima as a separate and distinct public entity; and

WHEREAS, CalOptima is committed to compliance with the requirements of the Ralph M. Brown Act (Brown Act) to provide transparency, public access, and opportunities to participate in meetings of CalOptima's Board of Directors and its advisory committees.

WHEREAS, on March 4, 2020, pursuant to Government Code section 8625, the Governor of California declared a state of emergency in response to the COVID-19 pandemic; and

WHEREAS, on March 17, 2020, the Governor issued Executive Order N-29-20, which suspended certain requirements under the Brown Act and modified the teleconference requirements to allow legislative bodies of public agencies to hold public meetings via teleconference; and

WHEREAS, on June 4, 2021, the Governor clarified that the "reopening" of California on June 15, 2021, did not include any change to the declared state of emergency or the powers exercised thereunder; and

WHEREAS, on June 11, 2021, the Governor issued Executive Order N-08-21, which extended the provision of Executive Order N-29-20 concerning the conduct of public meetings through September 30, 2021; and

WHEREAS, California Assembly Bill (AB) 361 was signed into law effective September 16, 2021, which amended the teleconferencing requirement under the Brown Act provision in Government Code section 54953; and

WHEREAS, Government Code section 54953, subdivision (b)(3) permits public meetings by teleconference, but requires: the agendas to be posted at all teleconference locations; each teleconference location be identified in the notice and agenda of the meeting or proceeding; and each teleconference location be accessible to the public; and

WHREREAS, Government Code section 54953, subdivision (e) provides an alternative to having public meetings in accordance with Government Code section 54953, subdivision (b)(3) when the circumstances of the COVID-19 state of emergency and the following circumstances exist: (1) The state of emergency as a result of COVID-19 continues to directly impact the ability of members of CalOptima's Board of Directors and members of CalOptima committees to meet safely in person; and (2) the State of California and/or the County of Orange continue to impose or recommend measures to promote social distancing; and

WHEREAS, as of the date of this Resolution, neither the Governor nor the Legislature have exercised their respective powers pursuant to California Government Code section 8629 to lift the state of emergency either by proclamation or by concurrent resolution of the state Legislature; and

WHEREAS, on October 12, 2021, the County of Orange Health Officer issued a revised "Orders and Strong Recommendations," which includes strong recommendations for preventative measures, such as avoiding gathering and practicing social distancing; and

WHEREAS, the continued local rates of transmission of the virus and variants causing COVID-19 are such that meeting in person could present imminent risks to the health or safety of attendees of CalOptima's public meetings if teleconference options are not included as an option for participation; and,

WHEREAS, the CalOptima Board of Directors and advisory committees have met remotely during the COVID-19 pandemic and can continue to do so in a manner that allows public participation and transparency while minimizing health risks to the Board members, staff, and public that would be present with in-person meetings while this state of emergency continues; and

WHEREAS, the Board of Directors has considered all information related to this matter and determined that it is in the best interest of the public and CalOptima that the Board of Directors meetings and advisory committee meetings of other CalOptima bodies be held via teleconference for the next thirty (30) days.

NOW, THEREFORE, BE IT RESOLVED:

I. That the CalOptima Board of Directors has duly considered the active status of the current state of emergency, along with the County of Orange Health Officer's strong recommendation to continue implementing COVID-19 preventative measures, such as social distancing, and has found that the state of emergency continues to directly impact the ability of the CalOptima Board of Directors and its advisory committees to meet safely in person,

II. That, as a result of the continued impact on the safety of the public and CalOptima officials, all CalOptima public meetings for the next thirty (30) days shall be conducted via teleconferencing, and such teleconferencing shall be carried out in compliance with California Government Code Section 54953, including, but not limited to, provisions protecting the statutory and constitutional rights of the public to attend and participate in such meetings.

III. That this Resolution shall take effect immediately upon its adoption and shall be effective until the earlier of (i) thirty (30) days after teleconferencing for the first time pursuant to Government Code section 54953(e), or (ii) such time that the CalOptima Board of Directors adopts a subsequent resolution in accordance with Government Code section 54953, subdivision (e)(3) to extend the time during which CalOptima's Board of Directors and advisory committees may continue to teleconference without compliance with Government Code section 54953, subdivision (e)(3)(b); and

IV. That the Chief Executive Officer of CalOptima is directed to place a resolution substantially similar to this resolution on the agenda of a future meeting of the CalOptima Board of Directors within the next thirty (30) days, or as soon thereafter as the CalOptima Board of Directors shall meet.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 4th day of November, 2021.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/_____
Printed Name and Title: Andrew Do, Chair, Board of Directors

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

EXECUTIVE DEPARTMENT
STATE OF CALIFORNIA

PROCLAMATION OF A STATE OF EMERGENCY

WHEREAS in December 2019, an outbreak of respiratory illness due to a novel coronavirus (a disease now known as COVID-19), was first identified in Wuhan City, Hubei Province, China, and has spread outside of China, impacting more than 75 countries, including the United States; and

WHEREAS the State of California has been working in close collaboration with the national Centers for Disease Control and Prevention (CDC), with the United States Health and Human Services Agency, and with local health departments since December 2019 to monitor and plan for the potential spread of COVID-19 to the United States; and

WHEREAS on January 23, 2020, the CDC activated its Emergency Response System to provide ongoing support for the response to COVID-19 across the country; and

WHEREAS on January 24, 2020, the California Department of Public Health activated its Medical and Health Coordination Center and on March 2, 2020, the Office of Emergency Services activated the State Operations Center to support and guide state and local actions to preserve public health; and

WHEREAS the California Department of Public Health has been in regular communication with hospitals, clinics and other health providers and has provided guidance to health facilities and providers regarding COVID-19; and

WHEREAS as of March 4, 2020, across the globe, there are more than 94,000 confirmed cases of COVID-19, tragically resulting in more than 3,000 deaths worldwide; and

WHEREAS as of March 4, 2020, there are 129 confirmed cases of COVID-19 in the United States, including 53 in California, and more than 9,400 Californians across 49 counties are in home monitoring based on possible travel-based exposure to the virus, and officials expect the number of cases in California, the United States, and worldwide to increase; and

WHEREAS for more than a decade California has had a robust pandemic influenza plan, supported local governments in the development of local plans, and required that state and local plans be regularly updated and exercised; and

WHEREAS California has a strong federal, state and local public health and health care delivery system that has effectively responded to prior events including the H1N1 influenza virus in 2009, and most recently Ebola; and

WHEREAS experts anticipate that while a high percentage of individuals affected by COVID-19 will experience mild flu-like symptoms, some will have more serious symptoms and require hospitalization, particularly individuals who are elderly or already have underlying chronic health conditions; and

WHEREAS it is imperative to prepare for and respond to suspected or confirmed COVID-19 cases in California, to implement measures to mitigate the spread of COVID-19, and to prepare to respond to an increasing number of individuals requiring medical care and hospitalization; and

WHEREAS if COVID-19 spreads in California at a rate comparable to the rate of spread in other countries, the number of persons requiring medical care may exceed locally available resources, and controlling outbreaks minimizes the risk to the public, maintains the health and safety of the people of California, and limits the spread of infection in our communities and within the healthcare delivery system; and

WHEREAS personal protective equipment (PPE) is not necessary for use by the general population but appropriate PPE is one of the most effective ways to preserve and protect California's healthcare workforce at this critical time and to prevent the spread of COVID-19 broadly; and

WHEREAS state and local health departments must use all available preventative measures to combat the spread of COVID-19, which will require access to services, personnel, equipment, facilities, and other resources, potentially including resources beyond those currently available, to prepare for and respond to any potential cases and the spread of the virus; and

WHEREAS I find that conditions of Government Code section 8558(b), relating to the declaration of a State of Emergency, have been met; and

WHEREAS I find that the conditions caused by COVID-19 are likely to require the combined forces of a mutual aid region or regions to appropriately respond; and

WHEREAS under the provisions of Government Code section 8625(c), I find that local authority is inadequate to cope with the threat posed by COVID-19; and

WHEREAS under the provisions of Government Code section 8571, I find that strict compliance with various statutes and regulations specified in this order would prevent, hinder, or delay appropriate actions to prevent and mitigate the effects of the COVID-19.

NOW, THEREFORE, I, GAVIN NEWSOM, Governor of the State of California, in accordance with the authority vested in me by the State Constitution and statutes, including the California Emergency Services Act, and in particular, Government Code section 8625, **HEREBY PROCLAIM A STATE OF EMERGENCY** to exist in California.

IT IS HEREBY ORDERED THAT:

1. In preparing for and responding to COVID-19, all agencies of the state government use and employ state personnel, equipment, and facilities or perform any and all activities consistent with the direction of the Office of Emergency Services and the State Emergency Plan, as well as the California Department of Public Health and the Emergency Medical Services Authority. Also, all residents are to heed the advice of emergency officials with regard to this emergency in order to protect their safety.

2. As necessary to assist local governments and for the protection of public health, state agencies shall enter into contracts to arrange for the procurement of materials, goods, and services needed to assist in preparing for, containing, responding to, mitigating the effects of, and recovering from the spread of COVID-19. Applicable provisions of the Government Code and the Public Contract Code, including but not limited to travel, advertising, and competitive bidding requirements, are suspended to the extent necessary to address the effects of COVID-19.

3. Any out-of-state personnel, including, but not limited to, medical personnel, entering California to assist in preparing for, responding to, mitigating the effects of, and recovering from COVID-19 shall be permitted to provide services in the same manner as prescribed in Government Code section 179.5, with respect to licensing and certification. Permission for any such individual rendering service is subject to the approval of the Director of the Emergency Medical Services Authority for medical personnel and the Director of the Office of Emergency Services for non-medical personnel and shall be in effect for a period of time not to exceed the duration of this emergency.

4. The time limitation set forth in Penal Code section 396, subdivision (b), prohibiting price gouging in time of emergency is hereby waived as it relates to emergency supplies and medical supplies. These price gouging protections shall be in effect through September 4, 2020.

5. Any state-owned properties that the Office of Emergency Services determines are suitable for use to assist in preparing for, responding to, mitigating the effects of, or recovering from COVID-19 shall be made available to the Office of Emergency Services for this purpose, notwithstanding any state or local law that would restrict, delay, or otherwise inhibit such use.

6. Any fairgrounds that the Office of Emergency Services determines are suitable to assist in preparing for, responding to, mitigating the effects of, or recovering from COVID-19 shall be made available to the Office of Emergency Services pursuant to the Emergency Services Act, Government Code section 8589. The Office of Emergency Services shall notify the fairgrounds of the intended use and can immediately use the fairgrounds without the fairground board of directors' approval, and

notwithstanding any state or local law that would restrict, delay, or otherwise inhibit such use.

7. The 30-day time period in Health and Safety Code section 101080, within which a local governing authority must renew a local health emergency, is hereby waived for the duration of this statewide emergency. Any such local health emergency will remain in effect until each local governing authority terminates its respective local health emergency.

8. The 60-day time period in Government Code section 8630, within which local government authorities must renew a local emergency, is hereby waived for the duration of this statewide emergency. Any local emergency proclaimed will remain in effect until each local governing authority terminates its respective local emergency.

9. The Office of Emergency Services shall provide assistance to local governments that have demonstrated extraordinary or disproportionate impacts from COVID-19, if appropriate and necessary, under the authority of the California Disaster Assistance Act, Government Code section 8680 et seq., and California Code of Regulations, Title 19, section 2900 et seq.

10. To ensure hospitals and other health facilities are able to adequately treat patients legally isolated as a result of COVID-19, the Director of the California Department of Public Health may waive any of the licensing requirements of Chapter 2 of Division 2 of the Health and Safety Code and accompanying regulations with respect to any hospital or health facility identified in Health and Safety Code section 1250. Any waiver shall include alternative measures that, under the circumstances, will allow the facilities to treat legally isolated patients while protecting public health and safety. Any facilities being granted a waiver shall be established and operated in accordance with the facility's required disaster and mass casualty plan. Any waivers granted pursuant to this paragraph shall be posted on the Department's website.

11. To support consistent practices across California, state departments, in coordination with the Office of Emergency Services, shall provide updated and specific guidance relating to preventing and mitigating COVID-19 to schools, employers, employees, first responders and community care facilities by no later than March 10, 2020.

12. To promptly respond for the protection of public health, state entities are, notwithstanding any other state or local law, authorized to share relevant medical information, limited to the patient's underlying health conditions, age, current condition, date of exposure, and possible contact tracing, as necessary to address the effect of the COVID-19 outbreak with state, local, federal, and nongovernmental partners, with such information to be used for the limited purposes of monitoring, investigation and control, and treatment and coordination of care. The

notification requirement of Civil Code section 1798.24, subdivision (i), is suspended.

13. Notwithstanding Health and Safety Code sections 1797.52 and 1797.218, during the course of this emergency, any EMT-P licensees shall have the authority to transport patients to medical facilities other than acute care hospitals when approved by the California EMS Authority. In order to carry out this order, to the extent that the provisions of Health and Safety Code sections 1797.52 and 1797.218 may prohibit EMT-P licensees from transporting patients to facilities other than acute care hospitals, those statutes are hereby suspended until the termination of this State of Emergency.

14. The Department of Social Services may, to the extent the Department deems necessary to respond to the threat of COVID-19, waive any provisions of the Health and Safety Code or Welfare and Institutions Code, and accompanying regulations, interim licensing standards, or other written policies or procedures with respect to the use, licensing, or approval of facilities or homes within the Department's jurisdiction set forth in the California Community Care Facilities Act (Health and Safety Code section 1500 et seq.), the California Child Day Care Facilities Act (Health and Safety Code section 1596.70 et seq.), and the California Residential Care Facilities for the Elderly Act (Health and Safety Code section 1569 et seq.). Any waivers granted pursuant to this paragraph shall be posted on the Department's website.

I FURTHER DIRECT that as soon as hereafter possible, this proclamation be filed in the Office of the Secretary of State and that widespread publicity and notice be given of this proclamation.

IN WITNESS WHEREOF I have hereunto set my hand and caused the Great Seal of the State of California to be affixed this 4th day of March 2020.

GAVIN NEWSOM
Governor of California

ATTEST:

ALEX PADILLA
Secretary of State

CLAYTON CHAU, MD PhD
DIRECTOR/COUNTY HEALTH OFFICER

REGINA CHINSIO-KWONG, DO
DEPUTY COUNTY HEALTH OFFICER

MATTHEW ZAHN, MD
DEPUTY COUNTY HEALTH OFFICER/MEDICAL DIRECTOR CDCD

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COUNTY OF ORANGE HEALTH OFFICER'S ORDERS AND STRONG RECOMMENDATIONS

(Revised October 12, 2021)

In light of the new and recent guidance on COVID-19 isolation and quarantine issued by California Department of Public Health (CDPH), the following **Orders and Strong Recommendations** shall revise and replace the prior Orders and Strong Recommendations of the County Health Officer that were issued on September 28, 2021. The Orders and Strong Recommendations issued on September 28, 2021, are no longer in effect as of October 12, 2021.

Pursuant to California Health and Safety Code sections 101030, 101040, 101470, 120175, and 120130, the County Health Officer for County of Orange orders and strongly recommends the following:

ORDERS

Effective immediately, and continuing until further notice, the following shall be in effect in unincorporated and incorporated territories of Orange County, California:

I. Self-Isolation and Self-Quarantine Orders

- **Self-isolation of Persons with COVID-19**.

  Persons with COVID-19 symptoms. All Orange County residents and visitors *with COVID-19 who are symptomatic* (as defined below) shall immediately isolate themselves in their home or another residence. They may discontinue self-isolation under the following conditions:

  - At least 10 days have passed since symptom onset; AND
  - At least 24 hours have passed since resolution of fever without the use of fever-reducing medications; AND

- Other symptoms have improved (except that loss of taste and smell may persist for weeks or months after recovery and need not delay the end of isolation).

Persons without COVID-19 symptoms. All Orange County residents and visitors *with COVID-19 who are asymptomatic* (i.e., they do not have any symptom(s), as defined below) shall isolate themselves immediately in their home or another residence. They may discontinue self-isolation under the following conditions:

- At least 10 days have passed since the first positive COVID-19 PCR or rapid antigen laboratory test.

Additional Considerations.

- A Person who is self-isolated may not leave his or her place of isolation except to receive necessary medical care.

- If a more specific and individualized isolation order is issued by the County Health Officer for any county resident, the resident shall follow the specific order instead of the order herein.

- People who are severely ill with COVID-19 might need to stay in self-isolation longer than 10 days and up to 20 days after symptoms first appeared. People with weakened immune systems may require testing to determine when they can be around others. Talk to your healthcare provider for more information. Your healthcare provider will let you know if you can resume being around other people based on the results of your testing.

This self-isolation order DOES NOT in any way restrict access by first responders to an isolation site during an emergency.

Definition.

- A person is considered to "*with COVID-19*" if the person has:
    - Received a positive COVID-19 PCR or rapid antigen laboratory test result; and/or
    - Exhibits symptoms (as defined below).

- People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. Anyone can have mild to severe symptoms. People with these symptoms may have COVID-19:
    - Fever or chills
    - Cough

- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

The list above does not include all possible symptoms.

- **Self-Quarantine of Persons Exposed to COVID-19 and Exemptions**.

All Orange County residents and visitors who know that they have been in close contact (within 6 feet of someone for a cumulative total of 15 minutes or more over a 24-hour period) with a person who has, or is suspected to have, COVID-19 and who do not have any symptoms (as defined above) shall take the following actions:

Not Fully Vaccinated Persons

- Stay in their home or another place of residence:
    - For at least 10 days from the date of last contact with a person who has COVID-19 without testing; OR
    - For at least 7 days with a negative COVID-19 diagnostic test result. Diagnostic specimen shall be collected on Day 5 or later from the date of last contact with person with COVID-19.
- The following persons shall quarantine themselves in their home or another place of residence for 14 days from the from the date of last contact with a person who has COVID-19:
    - All persons who reside or work in a high-risk congregate living setting (e.g., skilled nursing facilities, prisons, jails, shelters).
    - All persons who reside or work with severely immunosuppressed persons (e.g., Bone marrow or solid organ transplants, chemotherapy)

All persons who are required to self-quarantine, as specified above, shall also take the following additional actions:

- Self-monitor for COVID-19 symptoms through Day 14 from the date of last contact with a person who has COVID-19 and if any symptoms

develop during 14 days after the last date of close contact with a person with COVID-19, they shall immediately self-isolate themselves and contact the Orange County Health Care Agency or their healthcare provider and seek COVID-19 testing.

- Wear face coverings at all times through Day 14 and adhere to the face covering order specified in Section II, below, after Day 14;
- Perform frequent hand hygiene; and
- May not leave their place of quarantine during their quarantine period except to receive necessary medical care or to obtain such other goods or services necessary for their basic subsistence.

Exemptions:

1) **Asymptomatic Fully Vaccinated Persons.** Persons who are fully vaccinated for COVID-19 prior to their close contact with a person with COVID-19 and have not developed any symptoms (as defined above) since their exposure are not required to quarantine.

   - People are considered fully vaccinated for COVID-19:
     - 14 days or more after they have received the second dose in a 2-dose series (Pfizer-BioNTech or Moderna); or
     - 14 days or more after they have received a single-dose vaccine (Johnson and Johnson/Janssen).

2) **Asymptomatic Persons Previously Infected**. If an exposed person tested positive for COVID-19 before their new, recent close contact with a person with COVID-19 and it has been less than 3 months since they started having symptoms from that previous infection (or since their first positive COVID-19 test if asymptomatic), they do not need to quarantine, as long as they have not had any new symptoms since their recent exposure to COVID-19.

   All individuals who fall under any of the Exemptions, above, shall also take the following additional actions:

   - Test for COVID-19 3-5 days after last date of exposure (note: this requirement does not apply to *Asymptomatic Previously Infected Individuals*).
     - If they test positive, they shall immediately self-isolate, as ordered above, and contact their healthcare provider with any questions regarding their care.

- If they test negative, they shall continue monitoring their symptoms.

- Self-monitor for COVID-19 symptoms through Day 14 and if symptoms occur, immediately isolate as ordered above, they shall immediately self-isolate themselves and contact the Orange County Health Care Agency or their healthcare provider and seek COVID-19 testing.

3) **Quarantine Exemption for Students in both Private and Public Transitional Kindergarten through Grade 12.**

Quarantine Duration for *Unvaccinated* Students:

A. The following students shall quarantine, as stated under (2), below, if *any* of the following occur EITHER in the community OR in any indoor or at outdoor school settings, including on buses operated by public and private school systems:

- Either the student or person with COVID-19 (or both) was (were) NOT wearing face covering when they were within 6 feet of each other for a cumulative total of 15 minutes or more over a 24-hour period.

- Both student and person with COVID-19 were wearing face covering when they were within 6 feet of each other for a cumulative total of 15 minutes or more over a 24-hour period.

B. If the student (as defined in Paragraph (A), above) remains asymptomatic (meaning they have NOT had any COVID-19 symptoms, as defined in this Order, above), the student may discontinue self-quarantine under the following conditions:

i. Quarantine can end after Day 10 from the date of last exposure without testing for COVID-19; OR

ii. Quarantine can end after Day 7 if a test specimen (i.e., antigen diagnostic test, PCR/molecular diagnostic test, or pooled PCR/molecular test) is collected on or after Day 5 from the date of last exposure and the result is negative.

C. All quarantined students from Day 1 through Day 14 shall:

- Continue daily self-monitoring for symptoms through Day 14 from last known exposure; AND

- Follow all recommended non-pharmaceutical interventions (e.g., wearing a mask when around others, hand washing) through Day 14 from the Day of last known exposure.
- If any symptoms develop during this 14-day period, the exposed student shall immediately isolate as stated in this Order, above, get tested, and contact his or her healthcare provider with any questions regarding their care.

Exemption for Attending In-Person Instruction for Quarantined Unvaccinated Students – i.e., Modified Quarantine

If unvaccinated student and person with COVID-19 were wearing face covering when they were within 6 feet of each other for a cumulative total of 15 minutes or more over a 24-hour period, the exposed student may continue to attend school for in-person instruction during the duration of his or her quarantine period as specified in Paragraph (B), above, if the following conditions are met:

- The exposed student is asymptomatic; and
- The exposed student continues to appropriately wear face covering; and
- The exposed student undergoes at least twice weekly testing during his or her quarantine period (as specified in Paragraph (B), above); and
- The exposed student refrains from participation in all extracurricular activities at school, including sports, and activities within the community setting for the duration of his or her quarantine period (as stated in (B), above). The exposed student may participate in all required instructional components of the school day, except activities where a mask cannot be worn, such as while playing certain musical instruments. The exposed student may also eat meals on campus; and
- The exposed student complies with the conditions specified in Paragraph C, above.

4) **Acute Care Hospital Staff Shortage**. Acute care hospitals in collaboration with human resources and occupational health services that determine they are experiencing staff shortage and therefore are unable to provide safe patient care at their facilities may allow the following health care providers to continue to work onsite at their facilities throughout their 14-day exposure period: Asymptomatic health care providers, who are not fully vaccinated for COVID-19 and who have had a higher-risk exposure to COVID-19 but are not known to be infected. These health care providers shall be monitored for symptoms for COVID-19 and shall immediately isolate as consistent with the isolation order above if any symptoms develop (as defined above).

The above self-quarantine orders and exemptions DO NOT in any way restrict access by first responders to a quarantine site during an emergency.

II. Face-Covering Order:

1) **Wear a Cloth Face-Covering**. To help prevent the spread of droplets containing COVID-19, all County residents and visitors shall wear face coverings in accordance with and as required by the *Guidance for the Use of Face Coverings* issued by CDPH, effective July 28, 2021. The Guidance is attached herein as Attachment "**A**" and can be found at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/guidance-for-face-coverings.aspx. The Guidance orders, as follows:

Masking Requirements.

Masks are required for **all individuals** in the following indoor settings, regardless of vaccination status:

- On public transit (examples: airplanes, ships, ferries, trains, subways, buses, taxis, and ride-shares) and in transportation hubs (examples: airport, bus terminal, marina, train station, seaport or other port, subway station, or any other area that provides transportation)
- Indoors in K-12 schools, childcare
- Emergency shelters [4] and cooling centers

Masks are required for **all individuals**, in the following indoor settings, regardless of vaccination status (and surgical masks are recommended):

- Healthcare settings
- State and local correctional facilities and detention centers
- Homeless shelters
- Long Term Care Settings & Adult and Senior Care Facilities

Additionally, masks are required for unvaccinated individuals in indoor public settings and businesses (examples: retail, restaurants, theaters, family entertainment centers, meetings, state, and local government offices serving the public).

Guidance for Businesses, Venue Operators or Hosts.

In settings where masks are required only for unvaccinated individuals, businesses, venue operators or hosts may choose to:

- Provide information to all patrons, guests and attendees regarding vaccination requirements and allow vaccinated individuals to self-attest that they are in compliance prior to entry.
- Implement vaccine verification to determine whether individuals are required to wear a mask.
- Require all patrons to wear masks.

No person can be prevented from wearing a mask as a condition of participation in an activity or entry into a business.

Exemptions to masks requirements.

The following individuals are exempt from wearing masks at all times:

- Persons younger than two years old. Very young children must not wear a mask because of the risk of suffocation.
- Persons with a medical condition, mental health condition, or disability that prevents wearing a mask. This includes persons with a medical condition for whom wearing a mask could obstruct breathing or who are unconscious, incapacitated, or otherwise unable to remove a mask without assistance.
- Persons who are hearing impaired, or communicating with a person who is hearing impaired, where the ability to see the mouth is essential for communication.
- Persons for whom wearing a mask would create a risk to the person related to their work, as determined by local, state, or federal regulators or workplace safety guidelines.

Face shields may be considered for members of the public who cannot wear a face covering due to a medical condition or other exemption, although they may not work as well as face coverings in their ability to prevent the spread of COVID-19 to others. A cloth "drape" should be attached to the bottom edge of the face shield and tucked into the shirt to minimize gaps between the face and face shield.

III. Vaccination and Testing for COVID-19 Orders:

1) **COVID-19 Vaccination for Workers and Service Providers of Certain Facilities.** To help prevent transmission of COVID-19, all workers who provide services or

work in facilities described below shall comply with the vaccination requirements as set forth in the August 5, 2021, State Health Officer Order. A copy of the State Health Officer Order is attached herein as Attachment "**B**" and can be found at the following link:

https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx

The State Health Officer Order orders, as follows:

All workers who provide services or work in facilities described below shall have their first dose of a one-dose regimen or their second dose of a two-dose regimen by September 30, 2021:

- General Acute Care Hospitals
- Skilled Nursing Facilities (including Subacute Facilities)
- Intermediate Care Facilities
- Acute Psychiatric Hospitals
- Adult Day Health Care Centers
- Program of All-Inclusive Care for the Elderly (PACE) and PACE Centers
- Ambulatory Surgery Centers
- Chemical Dependency Recovery Hospitals
- Clinics & Doctor Offices (including behavioral health, surgical)
- Congregate Living Health Facilities
- Dialysis Centers
- Hospice Facilities
- Pediatric Day Health and Respite Care Facilities
- Residential Substance Use Treatment and Mental Health Treatment Facilities

Two-dose vaccines include Pfizer-BioNTech or Moderna or vaccine authorized by the World Health Organization. The one-dose vaccine is Johnson and Johnson [J&J]/Janssen.

"Worker" refers to all paid and unpaid individuals who work in indoor settings where (1) care is provided to patients, or (2) patients have access for any purpose. This includes workers serving in health care or other health care settings who have the potential for direct or indirect exposure to patients or SARS-CoV-2 airborne aerosols. Workers include, but are not limited to, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the health care facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the health care setting (e.g., clerical, dietary, environmental services, laundry,

security, engineering and facilities management, administrative, billing, and volunteer personnel).

Exemption from Vaccination. Workers may be exempt from the vaccination requirements under only upon providing the operator of the facility a declination form, signed by the individual stating either of the following: (1) the worker is declining vaccination based on Religious Beliefs, or (2) the worker is excused from receiving any COVID-19 vaccine due to Qualifying Medical Reasons.

Eligibility for Qualified Medical Reasons Exemption. To be eligible for a Qualified Medical Reasons exemption, the worker must also provide to their employer a written statement signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician stating that the individual qualifies for the exemption (but the statement should not describe the underlying medical condition or disability) and indicating the probable duration of the worker's inability to receive the vaccine (or if the duration is unknown or permanent, so indicate).

Condition of Entry into Facility for Exempted Workers. If an operator of facility deems a worker to have met the requirements of an exemption, the unvaccinated exempt worker must meet the following requirements when entering or working in such facility:

- Test for COVID-19 with either PCR or antigen test that either has Emergency Use Authorization by the U.S. Food and Drug Administration or be operating per the Laboratory Developed Test requirements by the U.S. Centers for Medicare and Medicaid Services. Testing must occur twice weekly for unvaccinated exempt workers in acute health care and long-term care settings, and once weekly for such workers in other health care settings.

- Wear a surgical mask or higher-level respirator approved by the National Institute of Occupational Safety and Health (NIOSH), such as an N95 filtering facepiece respirator, at all times while in the facility.

2) **Requirements for COVID-19 Vaccination Status Verification, COVID-19 Testing, and Masking for Certain Facilities**. To help prevent transmission of COVID-19, all facilities described below shall comply with the State Health Officer Order, effective August 9, 2021. A copy of the State Health Officer Order is attached herein as Attachment "**C**" and can be found at the following link:

https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Unvaccinated-Workers-In-High-Risk-Settings.aspx

Acute Health Care and Long-Term Care Settings:

- General Acute Care Hospitals
- Skilled Nursing Facilities (including Subacute Facilities)
- Intermediate Care Facilities

High-Risk Congregate Settings:

- Adult and Senior Care Facilities
- Homeless Shelters
- State and Local Correctional Facilities and Detention Centers

Other Health Care Settings:

- Acute Psychiatric Hospitals
- Adult Day Health Care Centers
- Adult Day Programs Licensed by the California Department of Social Services
- Program of All-Inclusive Care for the Elderly (PACE) and PACE Centers
- Ambulatory Surgery Centers
- Chemical Dependency Recovery Hospitals
- Clinics & Doctor Offices (including behavioral health, surgical)
- Congregate Living Health Facilities
- Dental Offices
- Dialysis Centers
- Hospice Facilities
- Pediatric Day Health and Respite Care Facilities
- Residential Substance Use Treatment and Mental Health Treatment Facilities

3) **Requirements for COVID-19 Vaccine Status Verification and COVID-19 Testing for School Workers in Transitional Kindergarten through Grade 12**. To prevent the further spread of COVID-19 in K-12 school settings, all public and private schools serving students in transitional kindergarten through grade 12 shall comply with the State Health Officer Order, effective August 12, 2021, regarding verification of COVID-19 vaccination status and COVID-19 testing of all workers. A copy of the State Health Officer Order is attached herein as Attachment "**D**" and can be found at the following link:

   https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Vaccine-Verification-for-Workers-in-Schools.aspx

   This Order does not apply to (i) home schools, (ii) child care settings, or (iii) higher education.

4) **Local Correctional Facilities and Detention Centers Health Care Worker Vaccination Requirement.** To prevent the further spread of COVID-19 in local

correctional facilities and detention centers, all individuals identified in the State Health Officer Order, effective August 19, 2021, regarding obtaining COVID-19 vaccination shall comply with the State Health Officer's Order. A copy of the State Health Officer Order is attached herein as Attachment "**E**" and can be found at the following link:

https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Correctional-Facilities-and-Detention-Centers-Health-Care-Worker-Vaccination-Order.aspx

IV. Visiting Acute Health Care and Long-Term Care Setting Order:

- **Requirements for Visiting Acute Health Care and Long-Term Care Settings**. To help prevent transmission of COVID-19, all acute health care and long-term care settings shall comply with the indoor visitation requirements set forth in the State Health Officer, effective August 11, 2021. A copy of the State Health Officer Order is attached herein as Attachment "**F**" and can be found at the following link:

  https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Requirements-for-Visitors-in-Acute-Health-Care-and-Long-Term-Care-Settings.aspx

V. Seasonal Flu Vaccination Order:

1) **Seasonal Flu Vaccination for Certain County Residents**. All individuals who reside or work in Orange County and fall under one of the following categories, shall obtain the seasonal flu vaccination unless a medical or religious exemption applies: (i) current providers for congregate settings; (ii) current health care providers; and (iii) current emergency responders. However, nothing herein shall be construed as an obligation, on the part of employers, public or private, to require employees obtain the seasonal flu vaccination as a term or condition of employment.

   - *Emergency responder* shall mean military or national guard; law enforcement officers; correctional institution personnel; fire fighters; emergency medical services personnel; physicians; nurses; public health personnel; emergency medical technicians; paramedics; emergency management personnel; 911 operators; child welfare workers and service providers; public works personnel; and persons with skills or training in operating specialized equipment or other skills needed to provide aid in a declared emergency; as well as individuals who work for such facilities employing these individuals and whose work is necessary to maintain the operation of the facility.

   - *Health care provider* shall mean physicians; psychiatrists; nurses; nurse practitioners; nurse assistants; medical technicians; any other person who is employed to provide diagnostic services, preventive services, treatment services or other services that are integrated with and necessary to the provision of patient care and, if not provided, would adversely impact patient care; and employees who directly assist or are supervised by a direct provider of diagnostic,

preventive, treatment, or other patient care services; and employees who do not provide direct heath care services to a patient but are otherwise integrated into and necessary to the provision those services – for example, a laboratory technician who processes medical test results to aid in the diagnosis and treatment of a health condition. A person is not a health care provider merely because his or her employer provides health care services or because he or she provides a service that affects the provision of health care services. For example, IT professionals, building maintenance staff, human resources personnel, cooks, food services workers, records managers, consultants, and billers are not health care providers, even if they work at a hospital of a similar health care facility.

STRONG RECOMMENDATIONS

Effective immediately, and continuing until further notice, the following shall be in effect in unincorporated and incorporated territories in Orange County, California:

1. **For Vulnerable Population.** In general, the older a person is, the more health conditions a person has, and the more severe the conditions, the more important it is to take preventive measures for COVID-19 such as getting vaccinated, social distancing and wearing a mask when around people who don't live in the same household, and practicing hand hygiene. For more information, see https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.

2. **COVID-19 Vaccination for County Residents**. All Orange County residents should receive COVID-19 vaccination in accordance with the Federal Food and Drug Administration (FDA) and CDC guidance unless a medical contraindication applies. Minors, who are eligible to receive COVID-19 vaccination in accordance with the applicable CDC guidelines, should be vaccinated in the presence of their parent or legal guardian.

3. **Seasonal Flu Vaccination for County Residents**. All County residents who are six months of age or older should obtain the seasonal flu vaccination unless a medical or religious exemption applies.

4. **COVID-19 Vaccination and Testing for Emergency Medical Technicians, Paramedics and Home Healthcare Providers**. To help prevent transmission of COVID-19, it is strongly recommended that all Emergency Medical Technicians, Paramedics, and Home Healthcare Providers (including In Home Supportive Services Program workers) are fully vaccinated by September 30, 2021.

   Furthermore, it is strongly recommended that all unvaccinated Emergency Medical Technicians, Paramedics, and Home Healthcare Providers (including In Home Supportive Services Program workers) undergo at least twice weekly testing for COVID-19 until such time they are fully vaccinated.

GENERAL PROVISIONS

1. The Orders and Strong Recommendations, above, shall not supersede any conflicting or more restrictive orders issued by the State of California or federal government. If any portion of this document or the application thereof to any person or circumstance is held to be invalid, the remainder of the document, including the application of such part or provision to other persons or circumstances, shall not be affected and shall continue in full force and effect. To this end, the provisions of the orders and strong recommendations are severable.

2. The Orders contained in this document may be enforced by the Orange County Sheriff or Chiefs of Police pursuant to California Health and Safety Code section 101029, and California Government Code sections 26602 and 41601. A violation of a health order is subject to fine, imprisonment, or both (California Health and Safety Code section 120295).

REASONS FOR THE ORDERS AND STRONG RECOMMENDATIONS

1. On February 26, 2020, the County of Orange Health Officer declared a Local Health Emergency based on an imminent and proximate threat to public health from the introduction of COVID-19 in Orange County.
2. On February 26, 2020, the Chairwoman of the Board of Supervisors, acting as the Chair of Emergency Management Council, proclaimed a Local Emergency in that the imminent and proximate threat to public health from the introduction of COVID-19 created conditions of extreme peril to the safety of persons and property within the territorial limits of Orange County.
3. On March 2, 2020, the Orange County Board of Supervisors adopted Resolutions No. 20-011 and No. 20-012 ratifying the Local Health Emergency and Local Emergency, referenced above.
4. On March 4, 2020, the Governor of the State of California declared a State of Emergency to exist in California as a result of the threat of COVID-19.
5. As of October 12, 2021, the County has reported a total of 299,041 recorded confirmed COVID-19 cases and 5,499 COVID-19 related deaths.
6. Safe and effective authorized COVID-19 vaccines are recommended by the CDC. According to CDC, anyone infected with COVID-19 can spread it, even if they do NOT have symptoms. The novel coronavirus is spread in 3 ways:1) Breathing in air when close to an infected person who is exhaling small droplets and particles that contain the virus. 2) Having these small droplets and particles that contain virus land on the eyes, nose, or mouth, especially through splashes and sprays like a cough or sneeze. 3) Touching eyes, nose, or mouth with hands that have the virus on them. See https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html.

7. CDC requires face coverings on planes, buses, trains, and other forms of public transportation traveling into, within, or out of the United States and in U.S. transportation hubs such as airports and stations. See https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/about-face-coverings.html.

8. The CDPH issued a revised Guidance for the Use of Face Coverings, effective July 28, 2021, available at:

   https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/guidance-for-face-coverings.aspx

9. According to the CDC and CDPH, older adults, individuals with medical conditions, and pregnant and recently pregnant persons are at higher risk of severe illness when they contract COVID-19. See https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/index.html; see also https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/PublicHealthGuidanceSelfIsolationforOlderAdultsandThoseWhoHaveElevatedRisk.aspx.

10. The Orders and the Strong Recommendations contained in this document are based on the following facts, in addition to the facts stated under the foregoing paragraphs: (i) Safe and effective FDA authorized COVID-19 vaccines have become widely available, but many Orange County residents have not yet had the opportunity to be vaccinated, or have not completed their vaccination series to be fully vaccinated; (ii) there are currently limited therapeutic options proven effective that consistently prevents the severe illness associated with COVID-19; (iii) the current consensus among public health officials for slowing down the transmission of and avoiding contracting COVID-19 is for unvaccinated persons to avoid gathering and practice social distancing, frequently wash hands with soap, wearing face covering and get vaccinated; (iv) some individuals who contract COVID-19 have no symptoms or have only mild symptoms and so are unaware that they carry the virus and are transmitting it to others; (v) current evidence shows that the novel coronavirus can survive on surfaces and can be indirectly transmitted between individuals; (vi) older adults and individuals with medical conditions are at higher risk of severe illness; (vii) sustained COVID-19 community transmission continues to occur; (viii) the age, condition, and health of a significant portion of Orange County's residents place them at risk for serious health complications, including hospitalization and death, from COVID-19; (ix) younger and otherwise healthy people are also at risk for serious negative health outcomes and for transmitting the novel coronavirus to others.

11. The orders and strong recommendations contained in this document are necessary and less restrictive preventive measures to control and reduce the spread of COVID-19 in Orange County, help preserve critical and limited healthcare capacity in Orange County and save the lives of Orange County residents.

12. The California Health and Safety Code section 120175 requires the County of Orange Health Officer knowing or having reason to believe that any case of a communicable

disease exists or has recently existed within the County to take measures as may be necessary to prevent the spread of the disease or occurrence of additional cases.

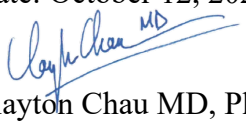
13. The California Health and Safety Code sections 101030 and 101470 require the county health officer to enforce and observe in the unincorporated territory of the county and within the city boundaries located with a county all of the following: (a) Orders and ordinances of the board of supervisors, pertaining to the public health and sanitary matters; (b) Orders, including quarantine and other regulations, prescribed by the department; and (c) Statutes relating to public health.

14. The California Health and Safety Code section 101040 authorizes the County of Orange Health Officer to take any preventive measure that may be necessary to protect and preserve the public health from any public health hazard during any "state of war emergency," "state of emergency," or "local emergency," as defined by Section 8558 of the Government Code, within his or her jurisdiction. "Preventive measure" means abatement, correction, removal, or any other protective step that may be taken against any public health hazard that is caused by a disaster and affects the public health.

15. The California Health and Safety Code section 120130 (d) authorizes the County of Orange Health Officer to require strict or modified isolation, or quarantine, for any case of contagious, infectious, or communicable disease, when such action is necessary for the protection of the public health.

IT IS SO ORDERED:

Date: October 12, 2021



Clayton Chau MD, PhD
County Health Officer
County of Orange

GOVERNMENT CODE - GOV

TITLE 5. LOCAL AGENCIES [50001 - 57607] *(Title 5 added by Stats. 1949, Ch. 81.)*
DIVISION 2. CITIES, COUNTIES, AND OTHER AGENCIES [53000 - 55821] *(Division 2 added by Stats. 1949, Ch. 81.)*
PART 1. POWERS AND DUTIES COMMON TO CITIES, COUNTIES, AND OTHER AGENCIES [53000 - 54999.7] *(Part 1 added by Stats. 1949, Ch. 81.)*

CHAPTER 9. Meetings [54950 - 54963] *(Chapter 9 added by Stats. 1953, Ch. 1588.)*

54953. (a) All meetings of the legislative body of a local agency shall be open and public, and all persons shall be permitted to attend any meeting of the legislative body of a local agency, except as otherwise provided in this chapter.

(b) (1) Notwithstanding any other provision of law, the legislative body of a local agency may use teleconferencing for the benefit of the public and the legislative body of a local agency in connection with any meeting or proceeding authorized by law. The teleconferenced meeting or proceeding shall comply with all otherwise applicable requirements of this chapter and all otherwise applicable provisions of law relating to a specific type of meeting or proceeding.

(2) Teleconferencing, as authorized by this section, may be used for all purposes in connection with any meeting within the subject matter jurisdiction of the legislative body. All votes taken during a teleconferenced meeting shall be by rollcall.

(3) If the legislative body of a local agency elects to use teleconferencing, it shall post agendas at all teleconference locations and conduct teleconference meetings in a manner that protects the statutory and constitutional rights of the parties or the public appearing before the legislative body of a local agency. Each teleconference location shall be identified in the notice and agenda of the meeting or proceeding, and each teleconference location shall be accessible to the public. During the teleconference, at least a quorum of the members of the legislative body shall participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction, except as provided in subdivisions (d) and (e). The agenda shall provide an opportunity for members of the public to address the legislative body directly pursuant to Section 54954.3 at each teleconference location.

(4) For the purposes of this section, “teleconference” means a meeting of a legislative body, the members of which are in different locations, connected by electronic means, through either audio or video, or both. Nothing in this section shall prohibit a local agency from providing the public with additional teleconference locations.

(c) (1) No legislative body shall take action by secret ballot, whether preliminary or final.

(2) The legislative body of a local agency shall publicly report any action taken and the vote or abstention on that action of each member present for the action.

(3) Prior to taking final action, the legislative body shall orally report a summary of a recommendation for a final action on the salaries, salary schedules, or compensation paid in the form of fringe benefits of a local agency executive, as defined in subdivision (d) of Section 3511.1, during the open meeting in which the final action is to be taken. This paragraph shall not affect the public’s right under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1) to inspect or copy records created or received in the process of developing the recommendation.

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(d) (1) Notwithstanding the provisions relating to a quorum in paragraph (3) of subdivision (b), if a health authority conducts a teleconference meeting, members who are outside the jurisdiction of the authority may be counted toward the establishment of a quorum when participating in the teleconference if at least 50 percent of the number of members that would establish a quorum are present within the boundaries of the territory over which the authority exercises jurisdiction, and the health authority provides a teleconference number, and associated access codes, if any, that allows any person to call in to participate in the meeting and the number and access codes are identified in the notice and agenda of the meeting.

(2) Nothing in this subdivision shall be construed as discouraging health authority members from regularly meeting at a common physical site within the jurisdiction of the authority or from using teleconference locations within or near the jurisdiction of the authority. A teleconference meeting for which a quorum is established pursuant to this subdivision shall be subject to all other requirements of this section.

(3) For purposes of this subdivision, a health authority means any entity created pursuant to Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.9605 of the Welfare and Institutions Code, any joint powers authority created pursuant to Article 1 (commencing with Section 6500) of Chapter 5 of Division 7 for the purpose of contracting pursuant to Section 14087.3 of the Welfare and Institutions Code, and any advisory committee to a county-sponsored health plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code if the advisory committee has 12 or more members.

(e) (1) A local agency may use teleconferencing without complying with the requirements of paragraph (3) of subdivision (b) if the legislative body complies with the requirements of paragraph (2) of this subdivision in any of the following circumstances:

(A) The legislative body holds a meeting during a proclaimed state of emergency, and state or local officials have imposed or recommended measures to promote social distancing.

(B) The legislative body holds a meeting during a proclaimed state of emergency for the purpose of determining, by majority vote, whether as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

(C) The legislative body holds a meeting during a proclaimed state of emergency and has determined, by majority vote, pursuant to subparagraph (B), that, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

(2) A legislative body that holds a meeting pursuant to this subdivision shall do all of the following:

(A) The legislative body shall give notice of the meeting and post agendas as otherwise required by this chapter.

(B) The legislative body shall allow members of the public to access the meeting and the agenda shall provide an opportunity for members of the public to address the legislative body directly pursuant to Section 54954.3. In each instance in which notice of the time of the teleconferenced meeting is otherwise given or the agenda for the meeting is otherwise posted, the legislative body shall also give notice of the means by which members of the public may access the meeting and offer public comment. The agenda shall identify and include an opportunity for all persons to attend via a call-in option or an internet-based service option. This subparagraph shall not be construed to require the legislative body to provide a physical location from which the public may attend or comment.

(C) The legislative body shall conduct teleconference meetings in a manner that protects the statutory and constitutional rights of the parties and the public appearing before the legislative body of a local agency.

(D) In the event of a disruption which prevents the public agency from broadcasting the meeting to members of the public using the call-in option or internet-based service option, or in the event of a disruption within the local agency's control which prevents members of the public from offering public comments using the call-in option or internet-based

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service option is restored. Actions taken on agenda items during a disruption which prevents the public agency from broadcasting the meeting may be challenged pursuant to Section 54960.1.

(E) The legislative body shall not require public comments to be submitted in advance of the meeting and must provide an opportunity for the public to address the legislative body and offer comment in real time. This subparagraph shall not be construed to require the legislative body to provide a physical location from which the public may attend or comment.

(F) Notwithstanding Section 54953.3, an individual desiring to provide public comment through the use of an internet website, or other online platform, not under the control of the local legislative body, that requires registration to log in to a teleconference may be required to register as required by the third-party internet website or online platform to participate.

(G) (i) A legislative body that provides a timed public comment period for each agenda item shall not close the public comment period for the agenda item, or the opportunity to register, pursuant to subparagraph (F), to provide public comment until that timed public comment period has elapsed.

(ii) A legislative body that does not provide a timed public comment period, but takes public comment separately on each agenda item, shall allow a reasonable amount of time per agenda item to allow public members the opportunity to provide public comment, including time for members of the public to register pursuant to subparagraph (F), or otherwise be recognized for the purpose of providing public comment.

(iii) A legislative body that provides a timed general public comment period that does not correspond to a specific agenda item shall not close the public comment period or the opportunity to register, pursuant to subparagraph (F), until the timed general public comment period has elapsed.

(3) If a state of emergency remains active, or state or local officials have imposed or recommended measures to promote social distancing, in order to continue to teleconference without compliance with paragraph (3) of subdivision (b), the legislative body shall, not later than 30 days after teleconferencing for the first time pursuant to subparagraph (A), (B), or (C) of paragraph (1), and every 30 days thereafter, make the following findings by majority vote:

(A) The legislative body has reconsidered the circumstances of the state of emergency.

(B) Any of the following circumstances exist:

(i) The state of emergency continues to directly impact the ability of the members to meet safely in person.

(ii) State or local officials continue to impose or recommend measures to promote social distancing.

(4) For the purposes of this subdivision, “state of emergency” means a state of emergency proclaimed pursuant to Section 8625 of the California Emergency Services Act (Article 1 (commencing with Section 8550) of Chapter 7 of Division 1 of Title 2).

(f) This section shall remain in effect only until January 1, 2024, and as of that date is repealed.

(Amended by Stats. 2021, Ch. 165, Sec. 3. (AB 361) Effective September 16, 2021. Repealed as of January 1, 2024, by its own provisions. See later operative version added by Sec. 4 of Stats. 2021, Ch. 165.)

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Financial Summary

September 30, 2021

Board of Directors Meeting

November 4, 2021

Nancy Huang, Chief Financial Officer

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FY 2021–22: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - MTD: $1.9 million, favorable to budget $4.2 million or 185.2%
  - YTD: $12.2 million, favorable to budget $25.0 million or 196.1%
- Enrollment
  - MTD: 856,825 members, favorable to budget 14,889 or 1.8%
  - YTD: 2,554,478 members, favorable to budget 34,884 or 1.4%
- Revenue
  - MTD: $481.9 million, favorable to budget $150.6 million or 45.5% driven by Medi-Cal (MC) line of business (LOB):
    - $132.6 million of Fiscal Year (FY) 2020 hospital Directed Payments (DP)
    - $9.3 million of net Proposition 56 revenue due the extension of Proposition 56 by the Department of Health Care Services (DHCS) and Proposition 56 risk corridor
    - $4.0 million due to increase in Long-Term Care (LTC), pharmacy funding from DHCS, and Coordinated Care Initiative (CCI) revenue
  - YTD: $1.2 billion, favorable to budget $203.2 million or 20.5% driven by MC LOB:
    - $132.6 million of FY 2020 hospital DP
    - $40.3 million due to the extension of Proposition 56 and updates to the Proposition 56 risk corridor
    - $17.1 million due to favorable enrollment and increase in LTC, pharmacy funding from DHCS, and CCI

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FY 2021–22: Management Summary (cont.)

- Medical Expenses
  - MTD: $467.9 million, unfavorable to budget $148.1 million or 46.3% driven by MC LOB:
    - Reinsurance & Other expense unfavorable variance of $133.0 million primarily due to FY 2020 DP
    - Provider Capitation expense unfavorable variance of $12.3 million due to Proposition 56 estimates and short-term supplemental rate increase due to COVID-19
    - All other medical expense categories, with the exception of facilities, are experiencing higher than budgeted utilization. In addition, reflects the board approved short-term supplemental rate increase due to COVID-19
  - YTD: $1.1 billion, unfavorable to budget $184.4 million or 19.1% driven by MC LOB:
    - Reinsurance & Other expense unfavorable variance of $135.1 million due to FY 2020 DP
    - Provider Capitation expense unfavorable variance of $38.8 million due primarily to the extension of Proposition 56 and short-term supplemental rate increase due to COVID-19
    - All other medical expense categories with the exception of facilities are experiencing higher than budgeted utilization. In addition, reflects the board approved short-term supplemental rate increase due to COVID-19
- Administrative Expenses
  - MTD: $12.0 million, favorable to budget $2.6 million or 18.1%
  - YTD: $35.9 million, favorable to budget $7.2 million or 16.7%
- Net Investment & Other Income
  - MTD: ($0.1) million, unfavorable to budget $1.0 million or 115.5%
  - YTD: $1.5 million, unfavorable to budget $1.0 million or 40.4%

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FY 2021–22: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 97.1% (96.0% excluding DP), Budget 96.5%
  - YTD: Actual 96.1% (95.6% excluding DP), Budget 97.2%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 2.5% (3.4% excluding DP), Budget 4.4%
  - YTD: Actual 3.0% (3.4% excluding DP), Budget 4.3%
- Balance Sheet Ratios
  - Current ratio: 1.7
  - Board-designated reserve funds level: 1.74
  - Net position: $1.3 billion, including required Tangible Net Equity (TNE) of $106.0 million

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Enrollment Summary: September 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
118,567	117,101	1,466	1.3%	SPD	354,136	350,992	3,144	0.9%
299,389	296,833	2,556	0.9%	TANF Child	896,321	890,038	6,283	0.7%
110,684	106,717	3,967	3.7%	TANF Adult	328,352	319,316	9,036	2.8%
3,116	3,191	(75)	(2.4%)	LTC	9,310	9,573	(263)	(2.7%)
295,867	289,707	6,160	2.1%	MCE	879,006	864,664	14,342	1.7%
11,824	11,159	665	6.0%	WCM	35,531	33,477	2,054	6.1%
839,447	**824,708**	**14,739**	**1.8%**	**Medi-Cal Total**	**2,502,656**	**2,468,060**	**34,596**	**1.4%**
14,817	**15,059**	**(242)**	**(1.6%)**	**OneCare Connect**	**44,324**	**45,062**	**(738)**	**(1.6%)**
2,152	**1,771**	**381**	**21.5%**	**OneCare**	**6,281**	**5,284**	**997**	**18.9%**
409	**398**	**11**	**2.8%**	**PACE**	**1,217**	**1,188**	**29**	**2.4%**
856,825	**841,936**	**14,889**	**1.8%**	**CalOptima Total**	**2,554,478**	**2,519,594**	**34,884**	**1.4%**

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Financial Highlights: September 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
856,825	841,936	14,889	1.8%	Member Months	2,554,478	2,519,594	34,884	1.4%
481,870,062	331,295,696	150,574,366	45.5%	Revenues	1,194,742,364	991,515,980	203,226,384	20.5%
467,875,446	319,787,636	(148,087,810)	(46.3%)	Medical Expenses	1,148,055,520	963,641,860	(184,413,660)	(19.1%)
11,950,888	14,588,612	2,637,724	18.1%	Administrative Expenses	35,931,710	43,114,845	7,183,135	16.7%
2,043,729	**(3,080,552)**	**5,124,281**	**166.3%**	**Operating Margin**	**10,755,134**	**(15,240,725)**	**25,995,859**	**170.6%**
(128,992)	833,334	(962,326)	(115.5%)	Non Operating Income (Loss)	1,490,182	2,500,000	(1,009,818)	(40.4%)
1,914,737	**(2,247,218)**	**4,161,955**	**185.2%**	**Change in Net Assets**	**12,245,316**	**(12,740,725)**	**24,986,041**	**196.1%**
97.1%	96.5%	(0.6%)		Medical Loss Ratio	96.1%	97.2%	1.1%	
2.5%	4.4%	1.9%		Administrative Loss Ratio	3.0%	4.3%	1.3%	
0.4%	(0.9%)	1.4%		Operating Margin Ratio	0.9%	(1.5%)	2.4%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
96.0%	96.5%	0.5%		*MLR (excluding Directed Payments)	95.6%	97.2%	1.6%	
3.4%	4.4%	1.0%		*ALR (excluding Directed Payments)	3.4%	4.3%	1.0%	

*CalOptima updated the category of Directed Payments per Department of Health Care Services instructions

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Consolidated Performance Actual vs. Budget: September 2021(in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
1.5	(3.0)	4.6	Medi-Cal	8.5	(14.3)	22.8
0.4	(0.1)	0.6	OCC	2.0	(1.1)	3.1
(0.0)	(0.1)	0.0	OneCare	(0.2)	(0.3)	0.1
0.1	0.2	(0.1)	PACE	0.4	0.5	(0.1)
2.0	**(3.1)**	**5.1**	**Operating**	**10.8**	**(15.2)**	**26.0**
(0.1)	0.8	(1.0)	Inv./Rental Inc, MCO tax	1.5	2.5	(1.0)
(0.1)	**0.8**	**(1.0)**	**Non-Operating**	**1.5**	**2.5**	**(1.0)**
1.9	**(2.2)**	**4.2**	**TOTAL**	**12.2**	**(12.7)**	**25.0**

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Consolidated Revenue & Expenses: September 2021 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	531,756	295,867	11,824	839,447	14,817	2,152	409	856,825
REVENUES								
Capitation Revenue	240,313,596	$ 182,786,954	$ 24,791,008	$ 447,891,558	$ 27,770,802	$ 2,966,781	$ 3,240,922	$ 481,870,062
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	240,313,596	182,786,954	24,791,008	447,891,558	27,770,802	2,966,781	3,240,922	481,870,062
MEDICAL EXPENSES								
Provider Capitation	43,901,409	48,540,759	9,917,369	102,359,537	10,504,105	750,792		113,614,433
Facilities	24,999,808	25,149,765	4,828,111	54,977,684	4,477,219	1,034,199	859,189	61,348,291
Professional Claims	23,481,596	11,540,230	1,144,307	36,166,133	1,159,535	106,760	738,228	38,170,656
Prescription Drugs	23,169,266	31,105,922	6,492,420	60,767,608	6,957,253	896,343	359,382	68,980,586
MLTSS	35,405,071	4,024,571	2,003,628	41,433,269	1,605,555	27,397	44,997	43,111,218
Medical Management	2,365,904	1,411,390	296,889	4,074,183	1,104,241	30,617	819,532	6,028,573
Quality Incentives	1,454,808	940,591	50,763	2,446,163	220,485		5,113	2,671,760
Reinsurance & Other	83,677,277	50,026,501	10,112	133,713,890	108,357		127,681	133,949,928
Total Medical Expenses	238,455,139	172,739,729	24,743,600	435,938,468	26,136,750	2,846,107	2,954,121	467,875,446
Medical Loss Ratio	99.2%	94.5%	99.8%	97.3%	94.1%	95.9%	91.2%	97.1%
GROSS MARGIN	**1,858,457**	**10,047,226**	**47,408**	**11,953,090**	**1,634,052**	**120,674**	**286,800**	**13,994,617**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,858,531	747,374	76,672	121,587	7,804,164
Professional fees				160,220	73,326	16,000	3,083	252,628
Purchased services				967,935	130,077	13,548	16,436	1,127,996
Printing & Postage				256,951	76,423	5,756	12,556	351,686
Depreciation & Amortization				389,386			303	389,689
Other expenses				1,636,633	2,806		15,802	1,655,241
Indirect cost allocation & Occupancy				151,663	161,262	49,168	7,390	369,483
Total Administrative Expenses				10,421,319	1,191,267	161,144	177,157	11,950,888
Admin Loss Ratio				2.3%	4.3%	5.4%	5.5%	2.5%
INCOME (LOSS) FROM OPERATIONS				1,531,771	442,785	(40,470)	109,643	2,043,729
INVESTMENT INCOME								(410,894)
TOTAL MCO TAX				281,858				281,858
OTHER INCOME				45				45
CHANGE IN NET ASSETS				**$ 1,813,673**	**$ 442,785**	**$ (40,470)**	**$ 109,643**	**$ 1,914,737**
BUDGETED CHANGE IN NET ASSETS				(3,044,646)	(141,148)	(89,652)	194,894	(2,247,218)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 4,858,319	$ 583,933	$ 49,182	$ (85,251)	$ 4,161,955

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Consolidated Revenue & Expenses: September 2021 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	1,588,119	879,006	35,531	2,502,656	44,324	6,281	1,217	2,554,478
REVENUES								
Capitation Revenue	567,210,775	$ 451,386,826	$ 74,750,186	$ 1,093,347,787	$ 83,189,607	$ 8,257,683	$ 9,947,287	$ 1,194,742,364
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	567,210,775	451,386,826	74,750,186	1,093,347,787	83,189,607	8,257,683	9,947,287	1,194,742,364
MEDICAL EXPENSES								
Provider Capitation	133,513,035	147,050,196	27,305,477	307,868,707	31,866,975	2,286,725		342,022,407
Facilities	77,736,546	73,939,666	18,815,110	170,491,323	12,501,380	2,338,707	2,691,991	188,023,401
Professional Claims	69,363,371	33,036,327	4,345,313	106,745,011	3,321,756	362,968	2,251,263	112,680,998
Prescription Drugs	67,294,631	90,042,592	19,863,458	177,200,681	20,155,272	2,641,506	1,002,033	200,999,493
MLTSS	116,212,303	12,743,984	6,215,538	135,171,825	4,437,672	250,977	203,784	140,064,258
Medical Management	7,093,779	4,267,060	898,094	12,258,932	3,087,845	99,798	2,505,834	17,952,408
Quality Incentives	4,462,995	2,867,409	161,626	7,492,030	662,400		15,213	8,169,643
Reinsurance & Other	85,595,911	51,539,720	32,409	137,168,040	606,506		368,367	138,142,913
Total Medical Expenses	561,272,570	415,486,954	77,637,026	1,054,396,550	76,639,806	7,980,679	9,038,485	1,148,055,520
Medical Loss Ratio	99.0%	92.0%	103.9%	96.4%	92.1%	96.6%	90.9%	96.1%
GROSS MARGIN	**5,938,204**	**35,899,873**	**(2,886,839)**	**38,951,238**	**6,549,801**	**277,004**	**908,802**	**46,686,844**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				21,392,442	2,351,268	237,597	344,511	24,325,818
Professional fees				345,493	115,694	48,000	6,439	515,626
Purchased services				2,723,790	319,311	38,363	20,987	3,102,450
Printing & Postage				1,020,295	231,484	15,848	32,202	1,299,829
Depreciation & Amortization				1,225,481			5,051	1,230,532
Other expenses				4,324,510	3,156		23,564	4,351,230
Indirect cost allocation & Occupancy				(592,774)	1,521,368	151,016	26,615	1,106,224
Total Administrative Expenses				30,439,236	4,542,281	490,824	459,369	35,931,710
Admin Loss Ratio				2.8%	5.5%	5.9%	4.6%	3.0%
INCOME (LOSS) FROM OPERATIONS				8,512,002	2,007,519	(213,821)	449,434	10,755,134
INVESTMENT INCOME								906,419
TOTAL MCO TAX				583,693				583,693
OTHER INCOME				70				70
CHANGE IN NET ASSETS				**$ 9,095,765**	**$ 2,007,519**	**$ (213,821)**	**$ 449,434**	**$ 12,245,316**
BUDGETED CHANGE IN NET ASSETS				(14,318,249)	(1,090,141)	(341,206)	508,871	(12,740,725)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 23,414,014	$ 3,097,660	$ 127,385	$ (59,437)	$ 24,986,041

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Balance Sheet: As of September 2021

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$246,094,051	Accounts Payable	$48,209,621
Short-term Investments	1,183,285,213	Medical Claims liability	795,971,800
Capitation receivable	212,884,500	Accrued Payroll Liabilities	18,812,216
Receivables - Other	58,820,249	Deferred Revenue	9,924,885
Prepaid expenses	18,121,859	Deferred Lease Obligations	124,462
		Capitation and Withholds	164,945,869
Total Current Assets	**1,719,205,872**	**Total Current Liabilities**	**1,037,988,853**
Capital Assets			
Furniture & Equipment	46,251,085		
Building/Leasehold Improvements	6,211,579		
505 City Parkway West	51,777,223		
	104,239,887		
Less: accumulated depreciation	(59,427,815)		
Capital assets, net	44,812,072	Other (than pensions) post employment benefits liability	31,737,773
Other Assets		Net Pension Liabilities	30,488,751
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	56,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,100,215,376**
Cash and Cash Equivalents	4,497,575		
Investments	584,997,898	**Deferred Inflows**	
Total Board-designated Assets	589,495,474	Excess Earnings	344,198
		OPEB 75 Difference in Experience	536,000
Total Other Assets	646,594,387	Change in Assumptions	2,709,945
		OPEB Changes in Assumptions	773,000
		Net Position	
TOTAL ASSETS	**2,410,612,331**	TNE	105,987,982
		Funds in Excess of TNE	1,215,038,127
Deferred Outflows		**TOTAL NET POSITION**	1,321,026,109
Contributions	1,508,025		
Difference in Experience	3,236,721		
Excess Earning	2,104,780		
Changes in Assumptions	3,692,771		
OPEB 75 Changes in Assumptions	3,906,000		
Pension Contributions	544,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,425,604,628**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,425,604,628**

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Board Designated Reserve and TNE Analysis: As of September 2021

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	241,416,612				
	Tier 1 - MetLife	240,350,345				
Board-designated Reserve		481,766,957	368,581,364	571,968,227	113,185,592	(90,201,270)
	Tier 2 - Payden & Rygel	53,859,707				
	Tier 2 - MetLife	53,868,810				
TNE Requirement		107,728,517	105,987,982	105,987,982	1,740,535	1,740,535
	Consolidated:	**589,495,474**	**474,569,346**	**677,956,209**	**114,926,127**	**(88,460,735)**
	Current reserve level	*1.74*	*1.40*	*2.00*		

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Our Mission

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

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UNAUDITED FINANCIAL STATEMENTS

September 2021

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CalOptima - Consolidated
Financial Highlights
For the Three Months Ended September 30, 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
856,825	841,936	14,889	1.8%	Member Months	2,554,478	2,519,594	34,884	1.4%
481,870,062	331,295,696	150,574,366	45.5%	Revenues	1,194,742,364	991,515,980	203,226,384	20.5%
467,875,446	319,787,636	(148,087,810)	(46.3%)	Medical Expenses	1,148,055,520	963,641,860	(184,413,660)	(19.1%)
11,950,888	14,588,612	2,637,724	18.1%	Administrative Expenses	35,931,710	43,114,845	7,183,135	16.7%
2,043,729	**(3,080,552)**	**5,124,281**	**166.3%**	**Operating Margin**	**10,755,134**	**(15,240,725)**	**25,995,859**	**170.6%**
(128,992)	833,334	(962,326)	(115.5%)	Non Operating Income (Loss)	1,490,182	2,500,000	(1,009,818)	(40.4%)
1,914,737	**(2,247,218)**	**4,161,955**	**185.2%**	**Change in Net Assets**	**12,245,316**	**(12,740,725)**	**24,986,041**	**196.1%**
97.1%	96.5%	(0.6%)		Medical Loss Ratio	96.1%	97.2%	1.1%	
2.5%	4.4%	1.9%		Administrative Loss Ratio	3.0%	4.3%	1.3%	
0.4%	(0.9%)	1.4%		Operating Margin Ratio	0.9%	(1.5%)	2.4%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
96.0%	96.5%	0.5%		*MLR (excluding Directed Payments)	95.6%	97.2%	1.6%	
3.4%	4.4%	1.0%		*ALR (excluding Directed Payments)	3.4%	4.3%	1.0%	

*CalOptima updated the category of Directed Payments per Department of Health Care Services instructions

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CalOptima
Financial Dashboard
For the Three Months Ended September 30, 2021

MONTH - TO - DATE

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	839,447	824,708	14,739	1.8%
OneCare Connect	14,817	15,059	(242)	(1.6%)
OneCare	2,152	1,771	381	21.5%
PACE	409	398	11	2.8%
Total	856,825	841,936	14,889	1.8%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 1,814	$ (3,045)	$ 4,859	159.6%
OneCare Connect	443	(141)	584	414.2%
OneCare	(40)	(90)	50	55.6%
PACE	110	195	(85)	(43.6%)
505 Bldg.	-	-	-	0.0%
Investment Income & Other	(411)	833	(1,244)	(149.3%)
Total	$ 1,916	$ (2,248)	$ 4,164	185.2%

MLR	Actual	Budget	% Point Var
Medi-Cal	97.3%	96.9%	(0.4)
OneCare Connect	94.1%	93.9%	(0.3)
OneCare	95.9%	95.6%	(0.3)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 10,421	$ 12,345	$ 1,924	15.6%
OneCare Connect	1,191	1,837	645	35.1%
OneCare	161	179	18	10.1%
PACE	177	228	51	22.2%
Total	$ 11,951	$ 14,589	$ 2,638	18.1%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,079	1,219	140
OneCare Connect	195	210	14
OneCare	10	9	(1)
PACE	94	115	20
Total	1,378	1,552	174

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	778	677	102
OneCare Connect	76	72	4
OneCare	218	190	28
PACE	4	3	1
Total	1,077	942	134

YEAR - TO - DATE

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	2,502,656	2,468,060	34,596	1.4%
OneCare Connect	44,324	45,062	(738)	(1.6%)
OneCare	6,281	5,284	997	18.9%
PACE	1,217	1,188	29	2.4%
Total	2,554,478	2,519,594	34,884	1.4%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,096	$ (14,318)	$ 23,414	163.5%
OneCare Connect	2,008	(1,090)	3,098	284.2%
OneCare	(214)	(341)	127	37.2%
PACE	449	509	(60)	(11.8%)
505 Bldg.	-	-	-	0.0%
Investment Income & Other	906	2,500	(1,594)	(63.8%)
Total	$ 12,245	$ (12,740)	$ 24,985	196.1%

MLR	Actual	Budget	% Point Var
Medi-Cal	96.4%	97.6%	1.1
OneCare Connect	92.1%	94.6%	2.4
OneCare	96.6%	96.7%	0.1

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 30,439	$ 36,345	$ 5,906	16.2%
OneCare Connect	4,542	5,585	1,042	18.7%
OneCare	491	539	49	9.0%
PACE	459	646	186	28.9%
Total	$ 35,932	$ 43,115	$ 7,183	16.7%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	3,218	3,644	426
OneCare Connect	579	627	49
OneCare	30	28	(2)
PACE	277	335	58
Total	4,103	4,634	531

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	778	677	100
OneCare Connect	77	72	5
OneCare	212	189	23
PACE	4	4	1
Total	1,071	942	129

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended September 30, 2021

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	856,825		841,936		14,889	
REVENUE						
Medi-Cal	$ 447,891,558	$ 533.56	$ 298,455,782	$ 361.89	$ 149,435,776	$ 171.67
OneCare Connect	27,770,802	1,874.25	27,578,039	1,831.33	192,763	42.92
OneCare	2,966,781	1,378.62	2,034,814	1,148.96	931,967	229.66
PACE	3,240,922	7,924.01	3,227,061	8,108.19	13,861	(184.18)
Total Operating Revenue	481,870,062	562.39	331,295,696	393.49	150,574,366	168.90
MEDICAL EXPENSES						
Medi-Cal	435,938,468	519.32	289,155,433	350.62	(146,783,035)	(168.70)
OneCare Connect	26,136,750	1,763.97	25,882,661	1,718.75	(254,089)	(45.22)
OneCare	2,846,107	1,322.54	1,945,228	1,098.38	(900,879)	(224.16)
PACE	2,954,121	7,222.79	2,804,314	7,046.02	(149,807)	(176.77)
Total Medical Expenses	467,875,446	546.06	319,787,636	379.82	(148,087,810)	(166.24)
GROSS MARGIN	13,994,617	16.33	11,508,060	13.67	2,486,557	2.66
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,804,164	9.11	9,384,764	11.15	1,580,600	2.04
Professional fees	252,628	0.29	627,312	0.75	374,684	0.46
Purchased services	1,127,996	1.32	1,300,515	1.54	172,519	0.22
Printing & Postage	351,686	0.41	556,998	0.66	205,312	0.25
Depreciation & Amortization	389,689	0.45	492,900	0.59	103,211	0.14
Other expenses	1,655,241	1.93	1,787,189	2.12	131,948	0.19
Indirect cost allocation & Occupancy expense	369,483	0.43	438,934	0.52	69,451	0.09
Total Administrative Expenses	11,950,888	13.95	14,588,612	17.33	2,637,724	3.38
INCOME (LOSS) FROM OPERATIONS	2,043,729	2.39	(3,080,552)	(3.66)	5,124,281	6.05
INVESTMENT INCOME						
4 Interest income	561,686	0.66	833,334	0.99	(271,648)	(0.33)
3 Realized gain/(loss) on investments	640,265	0.75	-	-	640,265	0.75
2 Unrealized gain/(loss) on investments	(1,612,845)	(1.88)	-	-	(1,612,845)	(1.88)
Total Investment Income	(410,894)	(0.48)	833,334	0.99	(1,244,228)	(1.47)
TOTAL MCO TAX	281,858	0.33	-	-	281,858	0.33
OTHER INCOME	45	-	-	-	45	-
CHANGE IN NET ASSETS	**1,914,737**	**2.23**	**(2,247,218)**	**(2.67)**	**4,161,955**	**4.90**
MEDICAL LOSS RATIO	**97.1%**		**96.5%**		**-0.6%**	
ADMINISTRATIVE LOSS RATIO	**2.5%**		**4.4%**		**1.9%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2021

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	2,554,478		2,519,594		34,884	
REVENUE						
Medi-Cal	$ 1,093,347,787	$ 436.87	$ 893,015,396	$ 361.83	$ 200,332,391	$ 75.04
OneCare Connect	83,189,607	1,876.85	82,794,566	1,837.35	395,041	39.50
OneCare	8,257,683	1,314.71	6,075,319	1,149.76	2,182,364	164.95
PACE	9,947,287	8,173.61	9,630,699	8,106.65	316,588	66.96
Total Operating Revenue	1,194,742,364	467.71	991,515,980	393.52	203,226,384	74.19
MEDICAL EXPENSES						
Medi-Cal	1,054,396,550	421.31	870,988,613	352.90	(183,407,937)	(68.41)
OneCare Connect	76,639,806	1,729.08	78,300,043	1,737.61	1,660,237	8.53
OneCare	7,980,679	1,270.61	5,877,193	1,112.26	(2,103,486)	(158.35)
PACE	9,038,485	7,426.86	8,476,011	7,134.69	(562,474)	(292.17)
Total Medical Expenses	1,148,055,520	449.43	963,641,860	382.46	(184,413,660)	(66.97)
GROSS MARGIN	46,686,844	18.28	27,874,120	11.06	18,812,724	7.22
ADMINISTRATIVE EXPENSES						
Salaries and benefits	24,325,818	9.52	27,706,464	11.00	3,380,646	1.48
Professional fees	515,626	0.20	1,691,482	0.67	1,175,856	0.47
Purchased services	3,102,450	1.21	3,883,366	1.54	780,916	0.33
Printing & Postage	1,299,829	0.51	1,670,994	0.66	371,165	0.15
Depreciation & Amortization	1,230,532	0.48	1,478,700	0.59	248,168	0.11
Other expenses	4,351,230	1.70	5,367,037	2.13	1,015,807	0.43
Indirect cost allocation & Occupancy expense	1,106,224	0.43	1,316,802	0.52	210,578	0.09
Total Administrative Expenses	35,931,710	14.07	43,114,845	17.11	7,183,135	3.04
INCOME (LOSS) FROM OPERATIONS	10,755,134	4.21	(15,240,725)	(6.05)	25,995,859	10.26
INVESTMENT INCOME						
Interest income	1,723,547	0.67	2,500,000	0.99	(776,453)	(0.32)
Realized gain/(loss) on investments	889,343	0.35	-	-	889,343	0.35
Unrealized gain/(loss) on investments	(1,706,472)	(0.67)	-	-	(1,706,472)	(0.67)
Total Investment Income	906,419	0.35	2,500,000	0.99	(1,593,581)	(0.64)
TOTAL MCO TAX	583,693	0.23	-	-	583,693	0.23
OTHER INCOME	70	-	-	-	70	-
CHANGE IN NET ASSETS	**12,245,316**	**4.79**	**(12,740,725)**	**(5.06)**	**24,986,041**	**9.85**
MEDICAL LOSS RATIO	**96.1%**		**97.2%**		**1.1%**	
ADMINISTRATIVE LOSS RATIO	**3.0%**		**4.3%**		**1.3%**	

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CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended September 30, 2021

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	531,756	295,867	11,824	839,447	14,817	2,152	409	856,825
REVENUES								
Capitation Revenue	240,313,596	$ 182,786,954	$ 24,791,008	$ 447,891,558	$ 27,770,802	$ 2,966,781	$ 3,240,922	$ 481,870,062
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	240,313,596	182,786,954	24,791,008	447,891,558	27,770,802	2,966,781	3,240,922	481,870,062
MEDICAL EXPENSES								
Provider Capitation	43,901,409	48,540,759	9,917,369	102,359,537	10,504,105	750,792		113,614,433
Facilities	24,999,808	25,149,765	4,828,111	54,977,684	4,477,219	1,034,199	859,189	61,348,291
Professional Claims	23,481,596	11,540,230	1,144,307	36,166,133	1,159,535	106,760	738,228	38,170,656
Prescription Drugs	23,169,266	31,105,922	6,492,420	60,767,608	6,957,253	896,343	359,382	68,980,586
MLTSS	35,405,071	4,024,571	2,003,628	41,433,269	1,605,555	27,397	44,997	43,111,218
Medical Management	2,365,904	1,411,390	296,889	4,074,183	1,104,241	30,617	819,532	6,028,573
Quality Incentives	1,454,808	940,591	50,763	2,446,163	220,485		5,113	2,671,760
Reinsurance & Other	83,677,277	50,026,501	10,112	133,713,890	108,357		127,681	133,949,928
Total Medical Expenses	238,455,139	172,739,729	24,743,600	435,938,468	26,136,750	2,846,107	2,954,121	467,875,446
Medical Loss Ratio	99.2%	94.5%	99.8%	97.3%	94.1%	95.9%	91.2%	97.1%
GROSS MARGIN	**1,858,457**	**10,047,226**	**47,408**	**11,953,090**	**1,634,052**	**120,674**	**286,800**	**13,994,617**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,858,531	747,374	76,672	121,587	7,804,164
Professional fees				160,220	73,326	16,000	3,083	252,628
Purchased services				967,935	130,077	13,548	16,436	1,127,996
Printing & Postage				256,951	76,423	5,756	12,556	351,686
Depreciation & Amortization				389,386			303	389,689
Other expenses				1,636,633	2,806		15,802	1,655,241
Indirect cost allocation & Occupancy				151,663	161,262	49,168	7,390	369,483
Total Administrative Expenses				10,421,319	1,191,267	161,144	177,157	11,950,888
Admin Loss Ratio				2.3%	4.3%	5.4%	5.5%	2.5%
INCOME (LOSS) FROM OPERATIONS				1,531,771	442,785	(40,470)	109,643	2,043,729
INVESTMENT INCOME								(410,894)
TOTAL MCO TAX				281,858				281,858
OTHER INCOME				45				45
CHANGE IN NET ASSETS				**$ 1,813,673**	**$ 442,785**	**$ (40,470)**	**$ 109,643**	**$ 1,914,737**
BUDGETED CHANGE IN NET ASSETS				(3,044,646)	(141,148)	(89,652)	194,894	(2,247,218)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 4,858,319	$ 583,933	$ 49,182	$ (85,251)	$ 4,161,955

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CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Three Months Ended September 30, 2021

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	1,588,119	879,006	35,531	2,502,656	44,324	6,281	1,217	2,554,478
REVENUES								
Capitation Revenue	567,210,775	$ 451,386,826	$ 74,750,186	$ 1,093,347,787	$ 83,189,607	$ 8,257,683	$ 9,947,287	$ 1,194,742,364
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	567,210,775	451,386,826	74,750,186	1,093,347,787	83,189,607	8,257,683	9,947,287	1,194,742,364
MEDICAL EXPENSES								
Provider Capitation	133,513,035	147,050,196	27,305,477	307,868,707	31,866,975	2,286,725		342,022,407
Facilities	77,736,546	73,939,666	18,815,110	170,491,323	12,501,380	2,338,707	2,691,991	188,023,401
Professional Claims	69,363,371	33,036,327	4,345,313	106,745,011	3,321,756	362,968	2,251,263	112,680,998
Prescription Drugs	67,294,631	90,042,592	19,863,458	177,200,681	20,155,272	2,641,506	1,002,033	200,999,493
MLTSS	116,212,303	12,743,984	6,215,538	135,171,825	4,437,672	250,977	203,784	140,064,258
Medical Management	7,093,779	4,267,060	898,094	12,258,932	3,087,845	99,798	2,505,834	17,952,408
Quality Incentives	4,462,995	2,867,409	161,626	7,492,030	662,400		15,213	8,169,643
Reinsurance & Other	85,595,911	51,539,720	32,409	137,168,040	606,506		368,367	138,142,913
Total Medical Expenses	561,272,570	415,486,954	77,637,026	1,054,396,550	76,639,806	7,980,679	9,038,485	1,148,055,520
Medical Loss Ratio	99.0%	92.0%	103.9%	96.4%	92.1%	96.6%	90.9%	96.1%
GROSS MARGIN	**5,938,204**	**35,899,873**	**(2,886,839)**	**38,951,238**	**6,549,801**	**277,004**	**908,802**	**46,686,844**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				21,392,442	2,351,268	237,597	344,511	24,325,818
Professional fees				345,493	115,694	48,000	6,439	515,626
Purchased services				2,723,790	319,311	38,363	20,987	3,102,450
Printing & Postage				1,020,295	231,484	15,848	32,202	1,299,829
Depreciation & Amortization				1,225,481			5,051	1,230,532
Other expenses				4,324,510	3,156		23,564	4,351,230
Indirect cost allocation & Occupancy				(592,774)	1,521,368	151,016	26,615	1,106,224
Total Administrative Expenses				30,439,236	4,542,281	490,824	459,369	35,931,710
Admin Loss Ratio				2.8%	5.5%	5.9%	4.6%	3.0%
INCOME (LOSS) FROM OPERATIONS				8,512,002	2,007,519	(213,821)	449,434	10,755,134
INVESTMENT INCOME								906,419
TOTAL MCO TAX				583,693				583,693
OTHER INCOME				70				70
CHANGE IN NET ASSETS				**$ 9,095,765**	**$ 2,007,519**	**$ (213,821)**	**$ 449,434**	**$ 12,245,316**
BUDGETED CHANGE IN NET ASSETS				(14,318,249)	(1,090,141)	(341,206)	508,871	(12,740,725)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 23,414,014	$ 3,097,660	$ 127,385	$ (59,437)	$ 24,986,041

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September 30, 2021 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $1.9 million, $4.2 million favorable to budget
- Operating surplus is $2.0 million, with a deficit in non-operating income of $0.1 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $12.2 million, $25.0 million favorable to budget
- Operating surplus is $10.8 million, with a surplus in non-operating income of $1.5 million

Change in Net Assets by Line of Business (LOB) ($ millions):

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
1.5	(3.0)	4.6	Medi-Cal	8.5	(14.3)	22.8
0.4	(0.1)	0.6	OCC	2.0	(1.1)	3.1
(0.0)	(0.1)	0.0	OneCare	(0.2)	(0.3)	0.1
0.1	0.2	(0.1)	PACE	0.4	0.5	(0.1)
2.0	**(3.1)**	**5.1**	**Operating**	**10.8**	**(15.2)**	**26.0**
(0.1)	0.8	(1.0)	Inv./Rental Inc, MCO tax	1.5	2.5	(1.0)
(0.1)	**0.8**	**(1.0)**	**Non-Operating**	**1.5**	**2.5**	**(1.0)**
1.9	**(2.2)**	**4.2**	**TOTAL**	**12.2**	**(12.7)**	**25.0**

CalOptima - Consolidated
Enrollment Summary
For the Three Months Ended September 30, 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
118,567	117,101	1,466	1.3%	SPD	354,136	350,992	3,144	0.9%
299,389	296,833	2,556	0.9%	TANF Child	896,321	890,038	6,283	0.7%
110,684	106,717	3,967	3.7%	TANF Adult	328,352	319,316	9,036	2.8%
3,116	3,191	(75)	(2.4%)	LTC	9,310	9,573	(263)	(2.7%)
295,867	289,707	6,160	2.1%	MCE	879,006	864,664	14,342	1.7%
11,824	11,159	665	6.0%	WCM	35,531	33,477	2,054	6.1%
839,447	**824,708**	**14,739**	**1.8%**	**Medi-Cal Total**	**2,502,656**	**2,468,060**	**34,596**	**1.4%**
14,817	**15,059**	**(242)**	**(1.6%)**	**OneCare Connect**	**44,324**	**45,062**	**(738)**	**(1.6%)**
2,152	**1,771**	**381**	**21.5%**	**OneCare**	**6,281**	**5,284**	**997**	**18.9%**
409	**398**	**11**	**2.8%**	**PACE**	**1,217**	**1,188**	**29**	**2.4%**
856,825	**841,936**	**14,889**	**1.8%**	**CalOptima Total**	**2,554,478**	**2,519,594**	**34,884**	**1.4%**
				Enrollment (by Network)				
195,066	190,788	4,278	2.2%	HMO	582,099	570,644	11,455	2.0%
228,396	227,809	587	0.3%	PHC	683,659	682,378	1,281	0.2%
205,150	203,079	2,071	1.0%	Shared Risk Group	612,755	607,360	5,395	0.9%
210,835	203,032	7,803	3.8%	Fee for Service	624,143	607,678	16,465	2.7%
839,447	**824,708**	**14,739**	**1.8%**	**Medi-Cal Total**	**2,502,656**	**2,468,060**	**34,596**	**1.4%**
14,817	**15,059**	**(242)**	**(1.6%)**	**OneCare Connect**	**44,324**	**45,062**	**(738)**	**(1.6%)**
2,152	**1,771**	**381**	**21.5%**	**OneCare**	**6,281**	**5,284**	**997**	**18.9%**
409	**398**	**11**	**2.8%**	**PACE**	**1,217**	**1,188**	**29**	**2.4%**
856,825	**841,936**	**14,889**	**1.8%**	**CalOptima Total**	**2,554,478**	**2,519,594**	**34,884**	**1.4%**

CalOptima
Enrollment Trend by Network
Fiscal Year 2022

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	YTD Actual	YTD Budget	Variance
HMOs															
SPD	10,759	10,772	10,796										32,327	32,353	(26)
TANF Child	57,684	57,453	57,592										172,729	170,987	1,742
TANF Adult	33,827	34,099	34,339										102,265	99,106	3,159
LTC		1	3										4		4
MCE	88,797	89,334	90,159										268,290	262,168	6,122
WCM	2,114	2,193	2,177										6,484	6,030	454
Total	**193,181**	**193,852**	**195,066**										**582,099**	**570,644**	**11,455**
PHCs															
SPD	6,896	6,819	6,942										20,657	21,335	(678)
TANF Child	155,214	154,985	155,440										465,639	463,846	1,793
TANF Adult	14,006	14,054	14,197										42,257	41,258	999
LTC		2	1										3		3
MCE	44,256	44,359	44,580										133,195	135,323	(2,128)
WCM	7,304	7,368	7,236										21,908	20,616	1,292
Total	**227,676**	**227,587**	**228,396**										**683,659**	**682,378**	**1,281**
Shared Risk Groups															
SPD	10,063	10,104	10,074										30,241	30,967	(726)
TANF Child	59,085	58,837	58,641										176,563	178,593	(2,030)
TANF Adult	33,013	33,123	33,374										99,510	99,037	473
LTC	1	1	1										3		3
MCE	99,994	100,643	101,666										302,303	294,515	7,788
WCM	1,373	1,368	1,394										4,135	4,248	(113)
Total	**203,529**	**204,076**	**205,150**										**612,755**	**607,360**	**5,395**
Fee for Service (Dual)															
SPD	79,829	80,117	80,139										240,085	235,296	4,789
TANF Child	1	1	1										3		3
TANF Adult	1,318	1,351	1,392										4,061	3,484	577
LTC	2,788	2,778	2,806										8,372	8,661	(289)
MCE	3,612	3,813	4,013										11,438	7,729	3,709
WCM	16	16	18										50	45	5
Total	**87,564**	**88,076**	**88,369**										**264,009**	**255,215**	**8,794**
Fee for Service (Non-Dual - Total)															
SPD	10,163	10,047	10,616										30,826	31,041	(215)
TANF Child	26,720	26,952	27,715										81,387	76,612	4,775
TANF Adult	26,224	26,653	27,382										80,259	76,431	3,828
LTC	309	314	305										928	912	16
MCE	53,947	54,384	55,449										163,780	164,929	(1,149)
WCM	993	962	999										2,954	2,538	416
Total	**118,356**	**119,312**	**122,466**										**360,134**	**352,463**	**7,671**
SPD	117,710	117,859	118,567										354,136	350,992	3,144
TANF Child	298,704	298,228	299,389										896,321	890,038	6,283
TANF Adult	108,388	109,280	110,684										328,352	319,316	9,036
LTC	3,098	3,096	3,116										9,310	9,573	(263)
MCE	290,606	292,533	295,867										879,006	864,664	14,342
WCM	11,800	11,907	11,824										35,531	33,477	2,054
Total Medi-Cal MM	**830,306**	**832,903**	**839,447**										**2,502,656**	**2,468,060**	**34,596**
OneCare Connect	**14,688**	**14,819**	**14,817**										**44,324**	**45,062**	**(738)**
OneCare	**2,019**	**2,110**	**2,152**										**6,281**	**5,284**	**997**
PACE	**401**	**407**	**409**										**1,217**	**1,188**	**29**
Grand Total	**847,414**	**850,239**	**856,825**										**2,554,478**	**2,519,594**	**34,884**

ENROLLMENT:

Overall, September enrollment was 856,825

- Favorable to budget 14,889 or 1.8%
- Increased 6,586 or 0.8% from Prior Month (PM) (August 2021)
- Increased 68,905 or 8.7% from Prior Year (PY) (September 2021)

Medi-Cal enrollment was 839,447

- Favorable to budget 14,739 or 1.8%
  - Temporary Assistance for Needy Families (TANF) favorable 6,523
  - Medi-Cal Expansion (MCE) favorable 6,160
  - Seniors and Persons with Disabilities (SPD) favorable 1,466
  - Whole Child Model (WCM) favorable 665
  - Long-Term Care (LTC) unfavorable 75
- Increased 6,544 from PM

OneCare Connect enrollment was 14,817

- Unfavorable to budget 242 or 1.6%
- Decreased 2 from PM

OneCare enrollment was 2,152

- Favorable to budget 381 or 21.5%
- Increased 42 from PM

PACE enrollment was 409

- Favorable to budget 11 or 2.8%
- Increased 2 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
839,447	**824,708**	**14,739**	**1.8%**	**Member Months**	**2,502,656**	**2,468,060**	**34,596**	**1.4%**
				Revenues				
447,891,558	298,455,782	149,435,776	50.1%	Capitation Revenue	1,093,347,787	893,015,396	200,332,391	22.4%
-	-	-	0.0%	Other Income	-	-	-	0.0%
447,891,558	**298,455,782**	**149,435,776**	**50.1%**	**Total Operating Revenue**	**1,093,347,787**	**893,015,396**	**200,332,391**	**22.4%**
				Medical Expenses				
104,805,700	92,500,353	(12,305,347)	(13.3%)	Provider Capitation	315,360,737	276,575,094	(38,785,643)	(14.0%)
54,977,684	62,252,003	7,274,319	11.7%	Facilities Claims	170,491,323	186,666,699	16,175,376	8.7%
36,166,133	30,618,390	(5,547,743)	(18.1%)	Professional Claims	106,745,011	92,622,930	(14,122,081)	(15.2%)
60,767,608	56,291,569	(4,476,039)	(8.0%)	Prescription Drugs	177,200,681	171,746,278	(5,454,403)	(3.2%)
41,433,269	41,363,689	(69,580)	(0.2%)	MLTSS	135,171,825	125,647,685	(9,524,140)	(7.6%)
4,074,183	5,428,747	1,354,564	25.0%	Medical Management	12,258,932	15,627,877	3,368,945	21.6%
133,713,890	700,682	(133,013,208)	(18983.4%)	Reinsurance & Other	137,168,040	2,102,050	(135,065,990)	(6425.4%)
435,938,468	**289,155,433**	**(146,783,035)**	**(50.8%)**	**Total Medical Expenses**	**1,054,396,550**	**870,988,613**	**(183,407,937)**	**(21.1%)**
11,953,090	**9,300,349**	**2,652,741**	**28.5%**	**Gross Margin**	**38,951,238**	**22,026,783**	**16,924,455**	**76.8%**
				Administrative Expenses				
6,858,531	8,276,835	1,418,304	17.1%	Salaries, Wages & Employee Benefits	21,392,442	24,418,715	3,026,273	12.4%
160,220	586,229	426,009	72.7%	Professional Fees	345,493	1,493,233	1,147,740	76.9%
967,935	1,141,814	173,879	15.2%	Purchased Services	2,723,790	3,407,263	683,473	20.1%
256,951	383,828	126,877	33.1%	Printing and Postage	1,020,295	1,151,484	131,189	11.4%
389,386	492,500	103,114	20.9%	Depreciation & Amortization	1,225,481	1,477,500	252,019	17.1%
1,636,633	1,760,776	124,143	7.1%	Other Operating Expenses	4,324,510	5,287,798	963,288	18.2%
151,663	(296,987)	(448,650)	(151.1%)	Indirect Cost Allocation, Occupancy Expense	(592,774)	(890,961)	(298,187)	(33.5%)
10,421,319	**12,344,995**	**1,923,676**	**15.6%**	**Total Administrative Expenses**	**30,439,236**	**36,345,032**	**5,905,796**	**16.2%**
				Operating Tax				
14,136,024	13,888,078	247,946	1.8%	Tax Revenue	42,146,193	41,562,129	584,064	1.4%
13,854,167	13,888,078	33,911	0.2%	Premium Tax Expense	41,562,500	41,562,129	(371)	(0.0%)
-	-	-	0.0%	Sales Tax Expense	-	-	-	0.0%
281,858	-	281,858	**0.0%**	**Total Net Operating Tax**	583,693	-	583,693	**0.0%**
45	**-**	**45**	**0.0%**	**Other income**	**70**	**-**	**70**	**0.0%**
1,813,673	**(3,044,646)**	**4,858,319**	**159.6%**	**Change in Net Assets**	**9,095,765**	**(14,318,249)**	**23,414,014**	**163.5%**
97.3%	***96.9%***	***(0.4%)***	***(0.5%)***	***Medical Loss Ratio***	***96.4%***	***97.5%***	***1.1%***	***1.1%***
2.3%	***4.1%***	***1.8%***	***43.7%***	***Admin Loss Ratio***	***2.8%***	***4.1%***	***1.3%***	***31.6%***

MEDI-CAL INCOME STATEMENT– SEPTEMBER MONTH:

REVENUES of $447.9 million are favorable to budget $149.4 million driven by:

- Favorable volume related variance of $5.3 million
- Favorable price related variance of $144.1 million
  - $132.6 million of Fiscal Year (FY) 2020 hospital Directed Payments (DP)
  - $8.7 million of net Proposition 56 revenue due to the extension by the Department of Health Care Services (DHCS) and Proposition 56 risk corridor estimates
  - $4.0 million due to increase in LTC and pharmacy funding from DHCS in primary and Coordinated Care Initiative (CCI) revenue
  - Offset by $2.7 million due to Proposition 56 risk corridor
  - $1.8 million of PY Bridge Period Gross Medical Expenditures (GME) risk corridor estimates

MEDICAL EXPENSES of $435.9 million are unfavorable to budget $146.8 million driven by:

- Unfavorable volume related variance of $5.2 million
- Unfavorable price related variance of $141.6 million
  - Reinsurance & Other expense unfavorable variance of $133.0 million primarily due to FY 2020 DP
  - Provider Capitation expense unfavorable variance of $10.7 million due to Proposition 56 estimates and short-term supplemental rate increase due to COVID-19
  - Professional Claims expense unfavorable variance of $5.0 million due to Proposition 56 estimates and short-term supplemental rate increase due to COVID-19
  - Prescription Drugs expense unfavorable variance of $3.5 million
  - Offset by Facilities Claims expense favorable variance of $8.4 million due to Incurred But Not Reported (IBNR) claims

ADMINISTRATIVE EXPENSES of $10.4 million are favorable to budget $1.9 million driven by:

- Salaries & Benefit expense favorable to budget $1.4
- Other Non-Salary expense favorable to budget $0.5 million

CHANGE IN NET ASSETS is $1.8 million for the month, favorable to budget $4.9 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Three Months Ending September 30, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,817	**15,059**	**(242)**	**(1.6%)**	**Member Months**	**44,324**	**45,062**	**(738)**	**(1.6%)**
				Revenues				
2,713,442	2,808,847	(95,405)	(3.4%)	Medi-Cal Capitation Revenue	8,151,892	8,427,966	(276,074)	(3.3%)
17,751,211	19,062,722	(1,311,511)	(6.9%)	Medicare Capitation Revenue Part C	54,945,784	57,284,602	(2,338,818)	(4.1%)
7,306,149	5,706,470	1,599,679	28.0%	Medicare Capitation Revenue Part D	20,091,931	17,081,998	3,009,933	17.6%
-	-	-	0.0%	Other Income	-	-	-	0.0%
27,770,802	**27,578,039**	**192,763**	**0.7%**	**Total Operating Revenue**	**83,189,607**	**82,794,566**	**395,041**	**0.5%**
				Medical Expenses				
10,724,590	11,470,787	746,197	6.5%	Provider Capitation	32,529,375	34,473,786	1,944,411	5.6%
4,477,219	4,231,699	(245,520)	(5.8%)	Facilities Claims	12,501,380	12,822,432	321,052	2.5%
1,159,535	1,013,606	(145,929)	(14.4%)	Ancillary	3,321,756	3,091,900	(229,856)	(7.4%)
1,605,555	1,415,327	(190,228)	(13.4%)	MLTSS	4,437,672	4,349,820	(87,852)	(2.0%)
6,957,253	6,358,880	(598,373)	(9.4%)	Prescription Drugs	20,155,272	19,376,683	(778,589)	(4.0%)
1,104,241	1,219,539	115,298	9.5%	Medical Management	3,087,845	3,658,620	570,775	15.6%
108,357	172,823	64,466	37.3%	Other Medical Expenses	606,506	526,802	(79,704)	(15.1%)
26,136,750	**25,882,661**	**(254,089)**	**(1.0%)**	**Total Medical Expenses**	**76,639,806**	**78,300,043**	**1,660,237**	**2.1%**
1,634,052	**1,695,378**	**(61,326)**	**(3.6%)**	**Gross Margin**	**6,549,801**	**4,494,523**	**2,055,278**	**45.7%**
				Administrative Expenses				
747,374	876,930	129,556	14.8%	Salaries, Wages & Employee Benefits	2,351,268	2,630,876	279,608	10.6%
73,326	11,750	(61,576)	(524.0%)	Professional Fees	115,694	110,250	(5,444)	(4.9%)
130,077	108,609	(21,468)	(19.8%)	Purchased Services	319,311	325,827	6,516	2.0%
76,423	138,109	61,686	44.7%	Printing and Postage	231,484	414,327	182,843	44.1%
2,806	21,075	18,269	86.7%	Other Operating Expenses	3,156	63,225	60,069	95.0%
161,262	680,053	518,791	76.3%	Indirect Cost Allocation	1,521,368	2,040,159	518,791	25.4%
1,191,267	**1,836,526**	**645,259**	**35.1%**	**Total Administrative Expenses**	**4,542,281**	**5,584,664**	**1,042,383**	**18.7%**
442,785	**(141,148)**	**583,933**	**413.7%**	**Change in Net Assets**	**2,007,519**	**(1,090,141)**	**3,097,660**	**284.2%**
94.1%	***93.9%***	***(0.3%)***	***(0.3%)***	***Medical Loss Ratio***	***92.1%***	***94.6%***	***2.4%***	***2.6%***
4.3%	***6.7%***	***2.4%***	***35.6%***	***Admin Loss Ratio***	***5.5%***	***6.7%***	***1.3%***	***19.1%***

ONECARE CONNECT INCOME STATEMENT– SEPTEMBER MONTH:

REVENUES of $27.8 million are favorable to budget $0.2 million driven by:

- Unfavorable volume related variance of $0.4 million
- Favorable price related variance of $0.6 million

MEDICAL EXPENSES of $26.1 million are unfavorable to budget $0.3 million driven by:

- Favorable volume related variance of $0.4 million
- Unfavorable price related variance of $0.7 million
  - Prescription Drugs expense unfavorable variance of $0.7 million
  - Facilities Claims expense unfavorable variance of $0.3 million
  - MLTSS expense unfavorable variance of $0.2 million
  - Ancillary expense unfavorable variance of $0.2 million
  - Offset by Provider Capitation expense favorable variance of $0.6 million
  - Medical Management favorable variance of $0.1 million

ADMINISTRATIVE EXPENSES of $1.2 million are favorable to budget $0.6 million

CHANGE IN NET ASSETS is $0.4 million, favorable to budget $0.6 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
2,152	**1,771**	**381**	**21.5%**	**Member Months**	**6,281**	**5,284**	**997**	**18.9%**
				Revenues				
1,917,227	1,398,441	518,786	37.1%	Medicare Part C revenue	5,429,708	4,174,516	1,255,192	30.1%
1,049,554	636,373	413,181	64.9%	Medicare Part D revenue	2,827,975	1,900,803	927,172	48.8%
2,966,781	**2,034,814**	**931,967**	**45.8%**	**Total Operating Revenue**	**8,257,683**	**6,075,319**	**2,182,364**	**35.9%**
				Medical Expenses				
750,792	543,108	(207,684)	(38.2%)	Provider Capitation	2,286,725	1,621,241	(665,484)	(41.0%)
1,034,199	595,701	(438,498)	(73.6%)	Inpatient	2,338,707	1,790,286	(548,421)	(30.6%)
106,760	70,337	(36,423)	(51.8%)	Ancillary	362,968	213,910	(149,058)	(69.7%)
27,397	28,894	1,497	5.2%	Skilled Nursing Facilities	250,977	88,355	(162,622)	(184.1%)
896,343	660,942	(235,401)	(35.6%)	Prescription Drugs	2,641,506	2,009,870	(631,636)	(31.4%)
30,617	44,936	14,319	31.9%	Medical Management	99,798	149,622	49,824	33.3%
-	1,310	1,310	100.0%	Other Medical Expenses	-	3,909	3,909	100.0%
2,846,107	**1,945,228**	**(900,879)**	**(46.3%)**	**Total Medical Expenses**	**7,980,679**	**5,877,193**	**(2,103,486)**	**(35.8%)**
120,674	**89,586**	**31,088**	**34.7%**	**Gross Margin**	**277,004**	**198,126**	**78,878**	**39.8%**
				Administrative Expenses				
76,672	73,129	(3,543)	(4.8%)	Salaries, wages & employee benefits	237,597	221,005	(16,592)	(7.5%)
16,000	29,166	13,166	45.1%	Professional fees	48,000	87,498	39,498	45.1%
13,548	9,167	(4,381)	(47.8%)	Purchased services	38,363	27,501	(10,862)	(39.5%)
5,756	15,823	10,067	63.6%	Printing and postage	15,848	47,469	31,621	66.6%
-	1,029	1,029	100.0%	Other operating expenses	-	3,087	3,087	100.0%
49,168	50,924	1,756	3.4%	Indirect cost allocation, occupancy expense	151,016	152,772	1,756	1.1%
161,144	**179,238**	**18,094**	**10.1%**	**Total Administrative Expenses**	**490,824**	**539,332**	**48,508**	**9.0%**
(40,470)	**(89,652)**	**49,182**	**54.9%**	**Change in Net Assets**	**(213,821)**	**(341,206)**	**127,385**	**37.3%**
95.9%	***95.6%***	***(0.3%)***	***(0.4%)***	***Medical Loss Ratio***	***96.6%***	***96.7%***	***0.1%***	***0.1%***
5.4%	***8.8%***	***3.4%***	***38.3%***	***Admin Loss Ratio***	***5.9%***	***8.9%***	***2.9%***	***33.0%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
409	**398**	**11**	**2.8%**	**Member Months**	**1,217**	**1,188**	**29**	**2.4%**
				Revenues				
2,497,334	2,474,262	23,072	0.9%	Medi-Cal Capitation Revenue	7,504,140	7,385,927	118,213	1.6%
577,011	607,864	(30,853)	(5.1%)	Medicare Part C Revenue	1,772,308	1,812,116	(39,808)	(2.2%)
166,577	144,935	21,642	14.9%	Medicare Part D Revenue	670,840	432,656	238,184	55.1%
3,240,922	**3,227,061**	**13,861**	**0.4%**	**Total Operating Revenue**	**9,947,287**	**9,630,699**	**316,588**	**3.3%**
				Medical Expenses				
819,532	986,236	166,704	16.9%	Medical Management	2,505,834	2,943,840	438,006	14.9%
859,189	705,206	(153,983)	(21.8%)	Facilities Claims	2,691,991	2,148,244	(543,747)	(25.3%)
738,228	638,578	(99,650)	(15.6%)	Professional Claims	2,251,263	1,944,744	(306,519)	(15.8%)
127,681	125,720	(1,961)	(1.6%)	Patient Transportation	368,367	383,583	15,216	4.0%
359,382	308,971	(50,411)	(16.3%)	Prescription Drugs	1,002,033	935,972	(66,061)	(7.1%)
44,997	34,750	(10,247)	(29.5%)	MLTSS	203,784	104,820	(98,964)	(94.4%)
5,113	4,853	(260)	(5.3%)	Other Expenses	15,213	14,808	(405)	(2.7%)
2,954,121	**2,804,314**	**(149,807)**	**(5.3%)**	**Total Medical Expenses**	**9,038,485**	**8,476,011**	**(562,474)**	**(6.6%)**
286,800	**422,747**	**(135,947)**	**-32.2%**	**Gross Margin**	**908,802**	**1,154,688**	**(245,886)**	**-21.3%**
				Administrative Expenses				
121,587	157,870	36,283	23.0%	Salaries, wages & employee benefits	344,511	435,868	91,357	21.0%
3,083	167	(2,916)	(1746.1%)	Professional fees	6,439	501	(5,938)	(1185.1%)
16,436	40,925	24,489	59.8%	Purchased services	20,987	122,775	101,788	82.9%
12,556	19,238	6,682	34.7%	Printing and postage	32,202	57,714	25,512	44.2%
303	400	97	24.2%	Depreciation & amortization	5,051	1,200	(3,851)	(321.0%)
15,802	4,309	(11,493)	(266.7%)	Other operating expenses	23,564	12,927	(10,637)	(82.3%)
7,390	4,944	(2,446)	(49.5%)	Indirect Cost Allocation, Occupancy Expense	26,615	14,832	(11,783)	(79.4%)
177,157	**227,853**	**50,696**	**22.2%**	**Total Administrative Expenses**	**459,369**	**645,817**	**186,448**	**28.9%**
				Operating Tax				
6,070	-	6,070	0.0%	Tax Revenue	18,060	-	18,060	0.0%
6,070	-	(6,070)	0.0%	Premium Tax Expense	18,060	-	(18,060)	0.0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
109,643	**194,894**	**(85,251)**	**(43.7%)**	**Change in Net Assets**	**449,434**	**508,871**	**(59,437)**	**(11.7%)**
91.2%	***86.9%***	***(4.3%)***	***(4.9%)***	***Medical Loss Ratio***	***90.9%***	***88.0%***	***(2.9%)***	***(3.2%)***
5.5%	***7.1%***	***1.6%***	***22.6%***	***Admin Loss Ratio***	***4.6%***	***6.7%***	***2.1%***	***31.1%***

CalOptima
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Administrative Expenses				
36,931	54,250	17,319	31.9%	Purchase services	112,259	162,750	50,491	31.0%
172,617	206,000	33,383	16.2%	Depreciation & amortization	517,852	618,000	100,148	16.2%
19,565	19,750	185	0.9%	Insurance expense	58,694	59,250	556	0.9%
83,832	131,583	47,751	36.3%	Repair and maintenance	279,209	394,749	115,540	29.3%
65,565	43,000	(22,565)	(52.5%)	Other Operating Expense	200,577	129,000	(71,577)	(55.5%)
(378,510)	(454,583)	(76,073)	(16.7%)	Indirect allocation, Occupancy	(1,168,591)	(1,363,749)	(195,159)	(14.3%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

OTHER INCOME STATEMENTS – SEPTEMBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is ($40,470), favorable to budget $49,182

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.1 million, unfavorable to budget $0.1 million

CalOptima
Balance Sheet
September 30, 2021

ASSETS		**LIABILITIES & NET POSITION**	
Current Assets		Current Liabilities	
Operating Cash	$246,094,051	Accounts Payable	$48,209,621
Short-term Investments	1,183,285,213	Medical Claims liability	795,971,800
Capitation receivable	212,884,500	Accrued Payroll Liabilities	18,812,216
Receivables - Other	58,820,249	Deferred Revenue	9,924,885
Prepaid expenses	18,121,859	Deferred Lease Obligations	124,462
		Capitation and Withholds	164,945,869
Total Current Assets	**1,719,205,872**	**Total Current Liabilities**	**1,037,988,853**
Capital Assets			
Furniture & Equipment	46,251,085		
Building/Leasehold Improvements	6,211,579		
505 City Parkway West	51,777,223		
	104,239,887		
Less: accumulated depreciation	(59,427,815)		
Capital assets, net	44,812,072	Other (than pensions) post employment benefits liability	31,737,773
Other Assets		Net Pension Liabilities	30,488,751
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	56,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,100,215,376**
Cash and Cash Equivalents	4,497,575		
Investments	584,997,898	Deferred Inflows	
Total Board-designated Assets	589,495,474	Excess Earnings	344,198
		OPEB 75 Difference in Experience	536,000
		Change in Assumptions	2,709,945
Total Other Assets	646,594,387	OPEB Changes in Assumptions	773,000
		Net Position	
TOTAL ASSETS	**2,410,612,331**	TNE	105,987,982
		Funds in Excess of TNE	1,215,038,127
Deferred Outflows		**TOTAL NET POSITION**	1,321,026,109
Contributions	1,508,025		
Difference in Experience	3,236,721		
Excess Earning	2,104,780		
Changes in Assumptions	3,692,771		
OPEB 75 Changes in Assumptions	3,906,000		
Pension Contributions	544,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,425,604,628**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,425,604,628**

CalOptima
Board Designated Reserve and TNE Analysis
as of September 30, 2021

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	241,416,612				
	Tier 1 - MetLife	240,350,345				
Board-designated Reserve		481,766,957	368,581,364	571,968,227	113,185,592	(90,201,270)
	Tier 2 - Payden & Rygel	53,859,707				
	Tier 2 - MetLife	53,868,810				
TNE Requirement		107,728,517	105,987,982	105,987,982	1,740,535	1,740,535
	Consolidated:	**589,495,474**	**474,569,346**	**677,956,209**	**114,926,127**	**(88,460,735)**
	Current reserve level	*1.74*	*1.40*	*2.00*		

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CalOptima
Statement of Cash Flows
September 30, 2021

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	1,914,737	12,245,316
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	562,306	1,748,384
Changes in assets and liabilities:		
Prepaid expenses and other	(1,683,772)	(6,143,248)
Catastrophic reserves		
Capitation receivable	23,491,508	203,191,269
Medical claims liability	22,947,788	(148,347,148)
Deferred revenue	(2,357,809)	(3,661,941)
Payable to health networks	8,702,617	20,166,081
Accounts payable	13,029,556	1,795,200
Accrued payroll	950,748	2,591,814
Other accrued liabilities	-	(2,867)
Net cash provided by/(used in) operating activities	67,557,680	83,582,862
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(117,747,759)	(117,875,407)
Change in Property and Equipment	(368,388)	(832,581)
Change in Board designated reserves	455,468	(615,322)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	(117,660,678)	(119,323,310)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(50,102,998)	(35,740,447)
CASH AND CASH EQUIVALENTS, beginning of period	$296,197,049	281,834,499
CASH AND CASH EQUIVALENTS, end of period	**246,094,051**	**246,094,051**

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BALANCE SHEET – SEPTEMBER MONTH:

ASSETS of $2.4 billion increased $45.2 million from August or 1.9%

- Operating Cash and Short-term Investments net increase of $67.6 million due to higher Centers for Medicare & Medicaid Services (CMS) capitation receipts and lower claim payments
  - Operating cash decreased $50.1 million
  - Short-term Investments increased $117.7 million
- Capitation Receivables decreased $28.0 million due to the timing of cash receipts

LIABILITIES of $1.1 billion increased $43.3 million from August or 4.1%

- Claims Liabilities increased $22.9 million due to timing of claim payments and changes in IBNR
- Accounts Payable increased $13.0 million due to the timing of accruals for the quarterly premium tax payment
- Capitation and Withhold increased $8.7 million due to timing of capitation payments

NET ASSETS of $1.3 billion, increased $1.9 million from August or 0.1%

Summary of Homeless Health Initiatives and Allocated Funds
As of September 30, 2021

			Amount
Program Commitment		**$**	**100,000,000**
Funds Allocation, approved initiatives:			
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000		
Recuperative Care	8,250,000		
Medical Respite	250,000		
Day Habilitation (County for HomeKey)	2,500,000		
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000		
CalOptima Homeless Response Team	6,000,000		
Homeless Coordination at Hospitals	10,000,000		
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,231,087		
FQHC (Community Health Center) Expansion and HHI Support	570,000		
HCAP Expansion for Telehealth and CFT On Call Days	1,000,000		
Vaccination Intervention and Member Incentive Strategy	400,000		
Funds Allocation Total		**$**	**43,201,087**
Program Commitment Balance, available for new initiatives*		**$**	**56,798,913**

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.

This report only lists Board approved projects.

* Funding sources of the remaining balance are IGT8 and CalOptima's operating income, which must be used for Medi-Cal covered services for the Medi-Cal population

Budget Allocation Changes
Reporting Changes for September 2021

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	No budget reallocations for July					
August	No budget reallocations for August					
September	No budget reallocations for September					

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors Meeting
November 4, 2021

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including, but not limited to, updates on internal and health network monitoring and audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare

- 2021 CMS Program Audit (applicable to OneCare and OneCare Connect):

  CMS conducted a program audit on both OneCare and OneCare Connect. CMS has released the preliminary draft audit report on 8/6/21 and completed the exit conference. On October 21, 2021, CMS issued the Draft Audit Report, which noted a total of 11 observations, eight Corrective Action Required (CARs), and one ICAR (which was issued on August 27th. The CAP for the ICAR was accepted by CMS on 9/13/21). CalOptima has until November 4, 2021 to submit any comments and rebuttals. CMS will then issue the Final Audit Report in November 2021 with a request for non-ICAR conditions requiring a CAP response within 30 calendar days of the final audit report issuance. Once CMS reviews the CAPs and accepts the CAP responses, CMS will follow up with a request to the plan to demonstrate correction of all conditions cited in the final audit report, by undergoing an independent validation audit (IVA). CalOptima will have 180 calendar days from the date of the CAP acceptance to complete the IVA and submit the validation audit report to CMS for review.

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2. PACE

- 2019 CMS Financial Audit:

On August 13, 2020, CMS notified CalOptima PACE that it has been selected for the 2019 CMS Financial Audit. By way of background, at least one-third of Medicare plan sponsors are selected for the annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CalOptima was notified that the Certified Public Accountant (CPA) firm, Myers & Stauffer, will be leading this audit. Myers & Stauffer will audit and inspect any books and records from CalOptima 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.

On December 4, 2020, Myers & Stauffer notified CalOptima of the selection of the prescription drug event (PDE) samples and associated documentation request. CalOptima submitted the full set of requested PDE samples to Myers & Stauffer ahead of the February 2, 2021, deadline. CalOptima has completed submission of all deliverables and is pending feedback from the auditor.

On April 1, 2021, Myers & Stauffer notified CalOptima they have provided a new documentation request list and will be conducting two sets of interviews during the week of April 12, 2021. On April 12, 2021, and April 15, 2021, Myers & Stauffer hosted a series of interview/conference calls to discuss CalOptima's oversight of delegated entities, policies and procedures related to fraud, waste, and abuse (FWA), and reporting of shared and/or intercompany expenses as they relate to PACE.

On June 15, 2021, Myers & Stauffer provided CalOptima with the Draft Report in advance of the Exit Conference scheduled for June 18, 2021. The draft report informs of one (1) finding and one (1) observation as a result of this audit activity.

On June 18, 2021, CalOptima attended the exit conference held by Myers & Stauffer. During the call, the draft report was reviewed along with next steps regarding agreeing and/or disagreeing with the findings and observations. On June 25, 2021, CalOptima submitted the Agree/Disagree letter to Myers & Stauffer rebutting the finding and agreeing with the observation noted within the draft report.

On July 29, 2021, CMS issued the Final Audit Report for the CY19 PACE One-Third Financial Audit. CMS cited 1 finding requiring corrective action, and 1 observation:

> Finding: The Plan was unable to substantiate the reclassification of certain expenses between patient care and non-patient care and the related allocation methodologies used to report non-benefit expenses on Worksheet 1 of the 2021 Part D bid. The total exposure to these reclassified expenses on Worksheet 1 of the Part D bid is $370,034.12, or $179.19 per-member per month (PMPM). There is no known beneficiary impact associated with this issue. CMS required CalOptima to complete a corrective action plan for this issue.

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Observation: Out of two P2P payments included in the 2019 P2P universe, one payment was not made within 30 days of CMS' notification. The total amount of the untimely P2P payments is $5.25. There is no known beneficiary impact associated with this issue. No corrective action plan is required.

On September 15, 2021, CalOptima submitted the CAP to CMS for the finding identified in the final report and is pending CMS review and feedback.

B. Regulatory Notices of Non-Compliance

- CalOptima did not receive any notices of non-compliance from its regulators for the month of September 2021.

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring: Medi-Cal[a\]

- Medi-Cal GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
June 2021	100%	100%	100%	100%	9%
July 2021	100%	100%	100%	100%	100%
August 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

  - ➢ No significant trends to report in July 2021.
  - ➢ August results will be available in the middle of October.

- Medi-Cal GARS: Expedited Appeals

Month(s)	Classification Score	Expedited Appeals Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Resolution of Expedited Appeals within 72 Hours of Receipt
June 2021	100%	N/A	100%	100%	88.88%
July 2021	100%	N/A	100%	100%	88.88%
August 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Based on a focused review of nine (9) Medi-Cal expedited appeals for July 2021, the lower compliance score of 88.88% for resolution of expedited appeals within 72 Hours of receipt was due to untimely resolution of one (1) expedited appeal.

- August results will be available in the middle of October.

- Medi-Cal GARS: Standard Grievances

Month(s)	Classification Score	Standard Grievances Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Standard Resolution of Grievances within ≤ 30 Calendar Days of Receipt
June 2021	100%	100%	95%	20%	100%
July 2021	100%	100%	100%	62.50%	100%
August 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

- Based on a focused review of twenty (20) Medi-Cal standard grievances for July 2021, the lower compliance score of 62.50% for member notice content was due to untimely resolutions of six (6) standard grievances.

- August results will be available in the middle of October.

- Medi-Cal GARS: Expedited Grievances

Month(s)	Classification Score	Expedited Grievances Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Expedited Grievances Resolved within ≤ 72 Hours of Receipt
June 2021	NTR	NTR	NTR	NTR	NTR
July 2021	100%	100%	100%	0%	100%
August 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

- Based on a focused review of four (4) Medi-Cal expedited grievances for July 2021, the lower compliance score of 0% for member notice content was due to the plan's response not properly addressing the member's concerns within four (4) expedited grievances.

- August results will be available in the middle of October.

[4] a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

- Medi-Cal Utilization Management: Standard Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
June 2021	100%	100%	100%	100%	100%	100%	100%
July 2021	100%	91.67%	100%	100%	100%	100%	100%
August 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

  - Based on a focused review of twelve (12) Medi-Cal standard prior authorizations for July 2021, the lower compliance score of 91.67% for resolution timeliness was due to untimely resolution of one (1) standard prior authorization.

  - August results will be available in the middle of October.

- Medi-Cal Utilization Management: Urgent Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
June 2021	100%	75%	100%	100%	100%	100%	100%
July 2021	100%	100%	100%	100%	100%	100%	66.67%
August 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

  - Based on a focused review of four (4) Medi-Cal urgent prior authorizations for July 2021, the lower compliance score of 66.67% for member notice content was due to one (1) urgent prior authorization not meeting the lay language criteria.

  - August results will be available in the middle of October.

[5] a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

3. Internal Monitoring: OneCare [a\]

- OneCare GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
June 2021	100%	100%	100%	0%	100%
July 2021	100%	100%	100%	0%	100%
August 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

  - Based on a focused review of two (2) OneCare standard appeals for July 2021, the lower compliance score of 0% for member notice content was due to two (2) files exceeding the sixth (6^{th}) grade reading level.
  - August results will be available in the middle of October.

- OneCare GARS: Payment Reconsiderations (PREC)

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
June 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
July 2021	100%	N/A	N/A	N/A	100%
August 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

  - No significant trends to report in July 2021.
  - August results will be available in the middle of October.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- OneCare GARS: Standard Grievances

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
June 2021	100%	100%	100%	100%	100%
July 2021	100%	100%	100%	100%	100%
August 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

  - ➢ No significant trends to report in July 2021.
  - ➢ August results will be available in the middle of October.

4. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
June 2021	100%	100%	100%	93.75%	100%
July 2021	100%	100%	100%	100%	66.67%
August 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

Based on a focused review of nine (9) OneCare Connect standard appeals for July 2021, the lower compliance score of 66.67% for member notice content was due to two (2) resolution letters exceeding the sixth (6th) grade reading level and one (1) appeal decision not including the complete provision which references the specific regulations or guidelines that support the appeal determination

  - ➢ August results will be available in the middle of October.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- OneCare Connect GARS: Standard Grievances

Month(s)	Classification Score	Standard Grievance Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Grievance within ≤ 30 Calendar Days of Receipt
June 2021	100%	100%	100%	93%	100%
July 2021	100%	100%	100%	100%	100%
August 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

  - No significant trends to report in July 2021.
  - August results will be available in the middle of October.

- OneCare Connect GARS: Expedited Grievances

Month(s)	Classification Score	Expedited Grievances Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Expedited Grievances Resolved within ≤ 72 Hours of Receipt
June 2021	100%	100%	100%	100%	100%
July 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
August 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

  - No significant trends to report in July 2021.
  - August results will be available in the middle of October.

[8] a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- OneCare Connect Utilization Management: Standard Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
June 2021	100%	100%	100%	95%	100%	100%	100%
July 2021	100%	100%	100%	100%	100%	100%	100%
August 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

  - No significant trends to report in July 2021.
  - August results will be available in the middle of October.

- OneCare Connect Utilization Management: Expedited Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
June 2021	100%	100%	100%	100%	100%	100%	100%
July 2021	100%	100%	100%	100%	100%	100%	100%
August 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

  - No significant trends to report in July 2021.
  - August results will be available in the middle of October.

5. Health Network Monitoring: Medi-Cal [a\]

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timely Urgent Requests	Clinical Decision Making (CDM) for Urgent Requests	Letter Score for Urgent Requests	Timely Routine Requests	Timely Denials	CDM for Denials	Letter Score for Denials	Timely Modified Requests	CDM for Modified Requests	Letter Score for Modified Requests	Timely Deferrals	CDM for Deferrals	Letter Score for Deferrals

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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May 2021	86%	89%	96%	86%	89%	88%	93%	99%	90%	97%	93%	97%	97%
June 2021	87%	93%	98%	92%	86%	94%	95%	95%	83%	98%	80%	100%	86%
July 2021	80%	90%	90%	81%	98%	96%	97%	92%	81%	96%	67%	89%	86%

- Based on a focused review of select files, nine (9) health networks drove the lower compliance score for timeliness during the month July 2021. Of the eighty-eight (88) files submitted in the aggregate by nine (9) health networks, twenty-one (21) files were deficient for timeliness. The deficiency for the lower scores for timeliness were due to the following:
  - Failure to meet timeframe for decision (Urgent 72 hours, Routine – 5 business days, and Extended– 14 calendar days)
  - Failure to meet timeframe for provider initial notification (24 hours & 5 business days)
  - Failure to meet timeframe for provider written notification (2 business days)
  - Failure to meet timeframe for member notification (2 business days& 5 business days)

- Based on a focused review of select files, five (5) health networks drove the lower compliance score for clinical decision making (CDM) during the month of July 2021. Of the forty-one (41) files submitted in the aggregate by five (5) health networks, thirty-three (33) files were deficient for CDM. The deficiency for the lower scores for CDM were due to the following:
  - Failure to cite criteria for decision

- Based on a focused review of select files, four (4) health network drove the lower compliance score for letter criteria during the month of July 2021. Of the forty (40) files submitted in the aggregate by the four (4) health network, nine (9) files were deficient for letter criteria. The deficiency for the lower scores for letter criteria were due to the following:
  - Failure to provide information on how to file appeal and grievance
  - Failure to provide letter in member preferred language
  - Failure to provide Language Assistance Taglines insert with approved threshold languages
  - Failure to provide description of service in lay language
  - Failure to provide why the request did not meet the criteria in lay language
  - Failure to provide name and contact information for health care professional responsible for the decision to deny or modify
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer

- Based on the overall universe of Medi-Cal authorizations for July 2021, CalOptima's health networks received an aggregate compliance score of 99.77% for timely

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processing of routine authorization requests and a compliance score of 96.41% for timely processing of expedited authorization requests.

- CalOptima's utilization management department issued requests for corrective action plans (CAPs) or Pre-CAP to all health networks with deficiencies identified during the focused review of prior authorization requests. The utilization management department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2021	94%	99%	99%	92%
June 2021	84%	94%	96%	95%
July 2021	91%	96%	92%	94%

- Based on a focused review of select files, eight (8) health networks drove the lower compliance score for Denied Claims Timeliness during the month of July 2021. Of the one hundred eighty-three (183) files submitted in the aggregate by eight (8) health networks, eighteen (18) files were deficient due to the failure to meet non-contracted denied claim timeliness (45 calendar day from date of claim receipt).

- Based on a focused review of select files, seven (7) health networks drove the lower compliance score for Denied Claims Accuracy during the month of July 2021. Of the two hundred & eight (208) files submitted in the aggregate by seven (7) health networks, seventeen (17) files were deficient for accuracy criteria. The deficiency for the lower scores for accuracy were due to the following:
  - Failure to provide all necessary documentation for clean claims processing
  - Failure to process correct payment rate on process claims
  - Failure to process claim correctly and denied in error
  - Failure to exclude duplicate claims from universe
  - Failure to correctly process payable services such as COVID-19

- Based on the overall universe of Medi-Cal claims for July 2021, CalOptima's health networks received an overall compliance score of 67% for timely processing of claims.

- CalOptima's claims department issued requests for corrective action plans (CAPs) or Pre-CAP to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The claims department continues to work with each health network to remediate the deficiencies by identifying accurate root causes

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and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

6. Health Network Monitoring: OneCare [a\]

- OneCare Utilization Management (UM): Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
May 2021	86%	84%	88%	88%	95%	100%	100%	98%
June 2021	100%	N/A	100%	96%	95%	94%	90%	98%
July 2021	100%	100%	96%	100%	94%	85%	100%	98%

- Based on a focused review of select files, one (1) health network drove the lower compliance score for timeliness during the month of July 2021. Of the ten (10) files submitted by the one (1) health network, six (6) files were deficient for timeliness. The deficiency for the lower scores for timeliness were due to the following:
  - Failure to meet timeframe for member notification (Routine – 14 calendar days)
  - Failure to meet timeframe for member notification (2 business days& 5 business days)

- Based on a focused review of select files, three (3) health networks drove the lower compliance score for letter criteria during the month of July 2021. Of the thirteen (13) files submitted in the aggregate by three (3) health networks, six (6) files were deficient for letter criteria. The deficiency for the lower scores for letter criteria were due to the following:
  - Failure to provide description of service in lay language
  - Failure to describe why the request did not meet criteria in lay language

- Based on the overall universe of OneCare authorization requests for CalOptima's health networks for July 2021, CalOptima's health networks received an overall compliance score 89% for timely processing of standard Part C authorization requests and 84% for timely processing of expedited Part C authorization requests.

- CalOptima's utilization management department issued requests for corrective action plans (CAPs) or Pre-CAP to all health networks with deficiencies identified during the review of prior authorization requests. The utilization management department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not

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be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2021	100%	100%	100%	100%
June 2021	97%	99%	100%	99%
July 2021	88%	100%	79%	91%

- Based on a focused review of select files, two (2) health networks drove the lower compliance score for Paid Claims Timeliness during the month of July 2021. Of the twenty-one (21) files submitted in the aggregate by the two (2) health networks, eight (8) file was deficient due to the failure to meet non-contracted paid claim timeliness (30 calendar day from date of claim receipt).

- Based on a focused review of select files, three (3) health networks drove the lower compliance score for Denied Claims Timeliness during the month of July 2021. Of the fifty-two (52) files submitted in the aggregate by the three (3) health networks, eight (8) file was deficient due to the failure to meet non-contracted paid claim timeliness (30 calendar day from date of claim receipt).

- Based on a focused review of select files, two (2) health network drove the lower compliance score for Denied Claims Accuracy during the month of July 2021. Of the fifteen (15) files submitted in the aggregate by two (1) health networks, five (5) file was deficient for accuracy criteria. The deficiency for the lower scores for accuracy were due to failure to the following:
  - Failure to provide all necessary documentation for clean claims processing
  - Failure to correctly process payable services

- Based on the overall universe of OneCare claims for July 2021, CalOptima's health networks received an overall compliance score of 70% for timely processing of claims.

- CalOptima's claims department issued requests for corrective action plans (CAPs) or Pre-CAP to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The claims department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy

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revisions to ensure timely and accurate processing of claims within regulatory requirements.

7. Health Network Monitoring: OneCare Connect [a\]

- OneCare Connect Utilization Management (UM): Prior Authorization Requests

Month	Timeliness for Urgent Requests	Clinical Decision Making (CDM) for Urgent Requests	Letter Score for Urgent Requests	Timeliness for Routine Requests	Letter Score for Routine Requests	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified Requests	CDM for Modified Requests	Letter Score for Modified Requests
May 2021	90%	100%	91%	87%	95%	98%	78%	93%	100%	100%	100%
June 2021	100%	100%	93%	97%	95%	94%	97%	98%	100%	89%	99%
July 2021	95%	89%	94%	93%	96%	90%	84%	97%	100%	87%	99%

- Based on a focused review of select files, three (3) health networks drove the lower compliance score for timeliness during the month of July 2021. Of the twenty-four (24) files submitted in the aggregate by the three (3) health networks, five (5) files were deficient for timeliness. The deficiency for the lower score for timeliness were due to the following:
  - Failure to meet timeframe for provider written notification (Urgent – 72 hours & Routine 5 – business days)
  - Failure to meet timeframe for provider initial notification (24 hours)

- Based on a focused review of select files, three (3) health network drove the lower compliance score for clinical decision making (CDM) during the month of July 2021. Of the seven (7) files submitted in the aggregate by three (3) health network, seven (7) files were deficient for CDM. The deficiency for the lower scores for CDM were due to the following:
  - Failure to cite criteria for decision

- Based on a focused review of select files, two (2) health network drove the lower compliance score for letter criteria during the month of July 2021. Of the seven (7) files submitted in the aggregate by the two (2) health network, three (3) file was deficient for letter criteria. The deficiency for the lower score for letter criteria were due to the following:
  - Failure to provide why the request did not meet the criteria in lay language
  - Failure to provide description of service in lay language

- Based on the overall universe of OneCare Connect authorization requests for CalOptima's health networks for July 2021, CalOptima's health networks received an overall compliance score of 100% for timely processing of routine authorization requests and 99% for timely processing of expedited authorization requests.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- CalOptima's utilization management department issued requests for corrective action plans (CAPs) or Pre-CAP to all health networks with deficiencies identified during the review of prior authorization requests. The utilization management department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2021	99%	98%	98%	94%
June 2021	84%	98%	99%	98%
July 2021	80%	83%	100%	97%

- Based on a focused review of select files, seven (7) health networks drove the lower compliance score for Paid Claims Timeliness during the month of July 2021. Of the seven (7) health networks that submitted fifty-nine (59) files in the aggregate, eighteen (18) files were deficient for timeliness. The deficiency for the lower score for timeliness was due to the failure to meet non-contracted clean denied claim timeliness (30 calendar day from date of claim receipt).

- Based on a focused review of selected files, five (5) health networks drove the lower compliance scores for Paid Claims Accuracy during the month of July 2021. Of the five (5) health networks that submitted fifty-nine (59) files in the aggregate, fifteen (15) files were deficient dud to the following:
  - Failure to document correct receipt date on claim
  - Failure to provide all necessary documentation for clean claims processing
  - Failure to pay claims with applicable interest rate
  - Failure to exclude duplicate claims from universe

- Based on a focused review of selected files, three (3) health networks drove the lower compliance scores for Denied Claims Accuracy during the month of July 2021. Of the three (3) health networks that submitted forty-two (42) files in the aggregate, four (4) files were deficient dud to the following:
  - Failure to process claims accuracy with payment, claims was denied in error

- Based on the overall universe of OneCare Connect claims for CalOptima's health networks for July 2021, CalOptima's health networks received the following overall compliance scores:
  - 95.60% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- 84.33% for non-contracted and contracted unclean claims paid or denied within 60 calendar days of receipt
- 99.74%% for non-contracted and contracted clean claims paid or denied within 90 calendar days of receipt

- CalOptima's claims management department issued requests for corrective action plans (CAPs) or Pre – CAP to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The claims department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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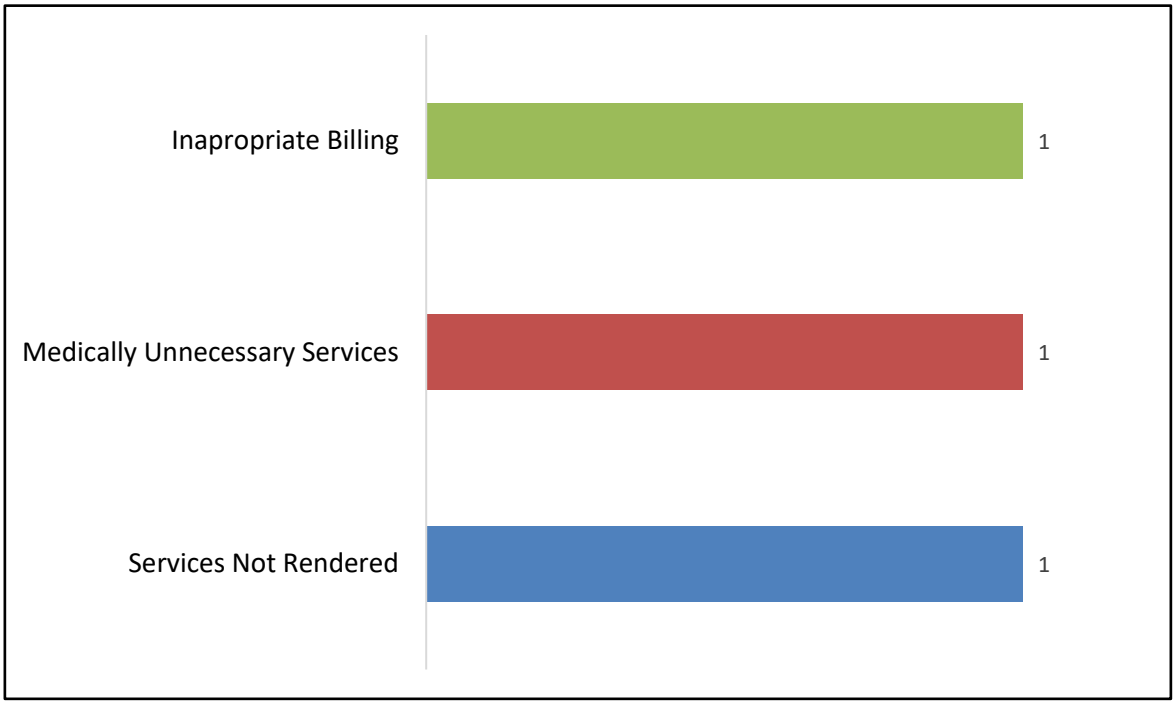
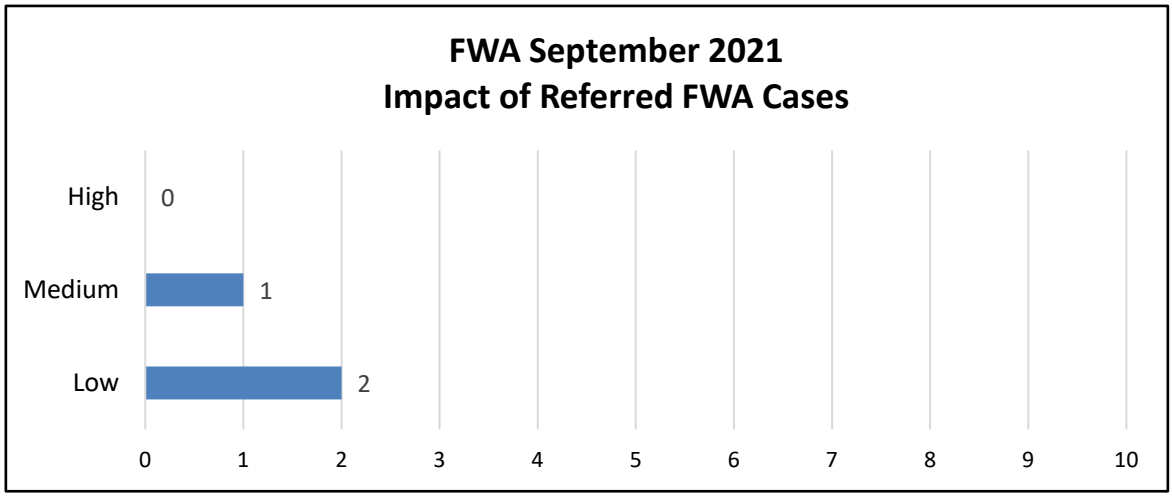
D. Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Referred in September 2021)





Total Number of New Cases Referred to DHCS (State)	3
Total Number of Closed Cases Referred to I-MEDIC (CMS)	0
Total Number of Referrals Reported	**3**

 a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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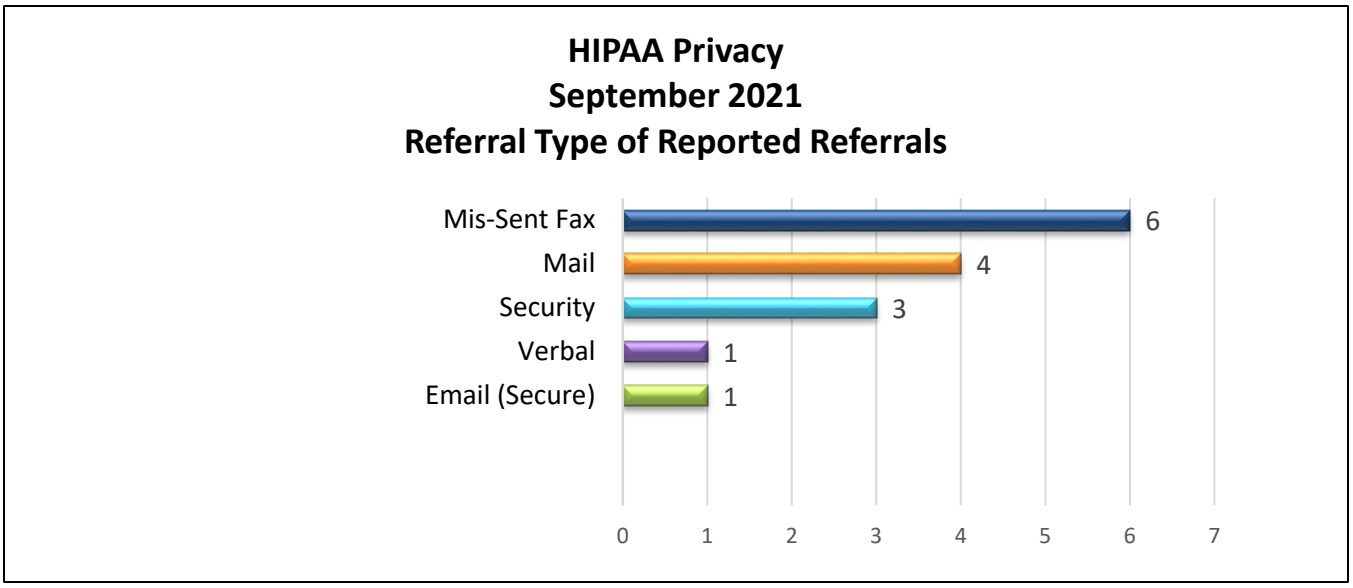
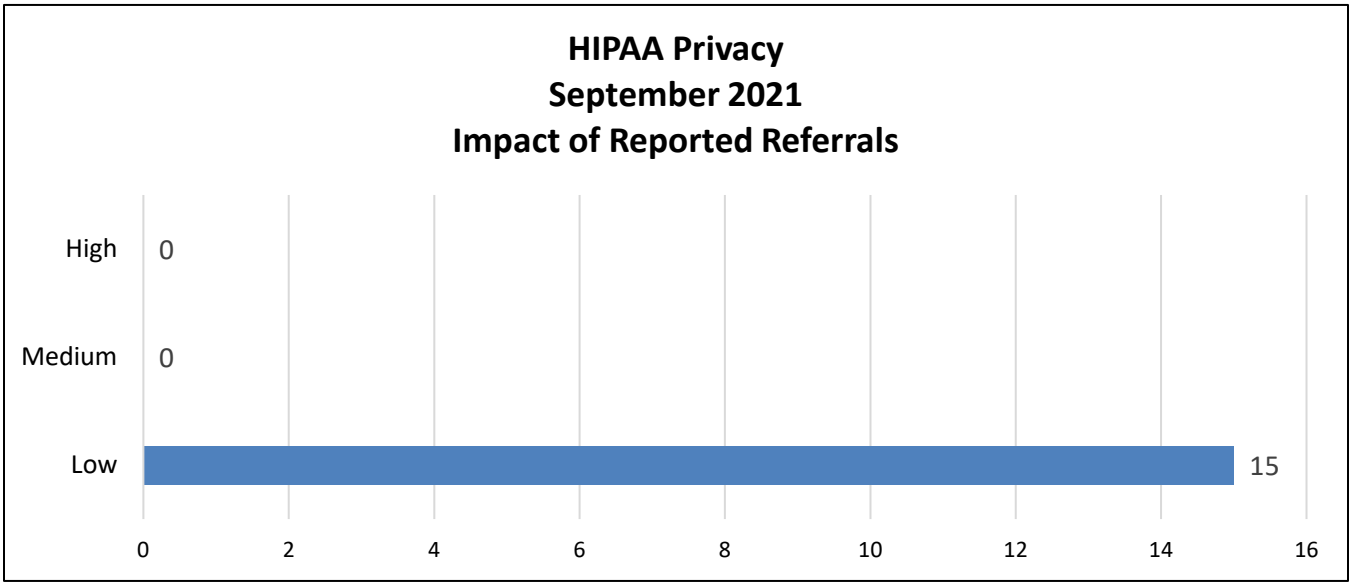
E. Privacy Update: (September 2021)





Total Number of Referrals Reported to DHCS (State)	15
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**15**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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POTOMAC PARTNERS DC

STRATEGIC HEALTH CARE

M E M O R A N D U M

October 8, 2021

To: CalOptima

From: Potomac Partners DC & Strategic Health Care

Re: October Board of Directors Report

FY22 Appropriations

The House and Senate were in session in the last two weeks of September. With the federal Fiscal Year 2021 (FY21) ending on September 30th, and none of the FY22 appropriations bills signed into law, Congress resorted to passing a Continuing Resolution (CR) that will expire on December 3rd, 2021. The CR (H.R. 5305) extends government funding at FY21 levels and provides an additional $35 billion in supplemental disaster and emergency relief spending.

We expect Congress to work on passing the FY22 appropriations bills using a series of minibus packages which contain the text of multiple appropriations bills in a single bill, or an omnibus containing all 12 spending bills. The Senate has yet to release most of their FY22 bills due to disagreements on topline numbers for defense spending, but Senate Appropriations staff have indicated that the committee is considering expedited committee approval procedures once topline numbers are agreed to. If an agreement cannot be reached by December 3rd, another Continuing Resolution will be necessary.

Infrastructure and Budget Reconciliation

At the time of this report, it appears the Infrastructure bill (IIJA-H.R. 3684) and the budget reconciliation package may be considered on the House floor before the end of October. While moderates in the House Democratic caucus had been pushing for an immediate vote on the Senate-passed infrastructure package, progressives see the IIJA as leverage to force consideration, and passage, of the budget reconciliation bill. Their concern remains that if they were to vote to pass the IIJA, moderates would only support the budget reconciliation if it was significantly pared down.

Instead of risking a failed floor vote, House Leadership delayed a scheduled vote on the IIJA and a 30-day extension was enacted on October 2nd (here). Although House Democratic leadership promised progressives a budget reconciliation "framework" agreement in return for votes on IIJA, negotiations on a framework hit a roadblock when Senator Joe Manchin (D-WV) announced he wanted the reconciliation bill capped at $1.5 trillion, or less than half of the $3.5 trillion House reconciliation package (which the vast majority of Democrats have voiced support for).

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DEBT CEILING NEGOTIATIONS

Congress also began work on a temporary debt limit increase in early October after US Treasury Secretary Janet Yellen sent a letter to Congress warning that the Federal Government will no longer be able to meet its debt obligations by October 18th. After many rounds of negotiations between Senate Democrats and Republicans, a deal was reached to raise the debt limit by $480 billion, which will likely last until December 3rd, 2021, when a new debt limit will be reached coinciding with the end of the CR. On October 7th the Senate voted 61-38 to begin debate on S. 1301, the vehicle for the debt limit. The House will likely return for a brief session to approve the bill once it passed the Senate. Senate Republicans have been staunchly opposed to the debt limit suspension originally proposed by Democrats that would have expired shortly after the 2022 midterm elections. Despite a short-term deal being reached on the debt limit, it is likely to be a major point of negotiations in late November as Democrats seek to enact the FY22 appropriations bills, infrastructure package, and budget reconciliation package.

HHS APP FOR SPANISH SPEAKERS AIMS TO HELP LATINOS PREPARE FOR APPOINTMENTS

On October 8th, the Department of Health and Human Services announced the launch of a Spanish language app to help Latino patients prepare for their in-person or telehealth appointments. Spanish speakers will now be able to use the *QuestionBuilder* app to prepare themselves for their medical appointments regardless of whether they are visiting a new medical provider or not. Users choose questions they want to ask their doctor, starting with a list of common questions that can be customized to fit individual needs. The app also allows users to input details of their upcoming appointments in Spanish, such as date and reason for the visit. Through the app, users can email information to themselves or others for reference and make notes during their medical visit.

Other features include:

- Content and questions organized by type of medical encounter, such as medical visit or preparing for surgery.
- Consumer education materials and videos about the importance of asking questions and sharing information.
- A camera option that allows users to document visual information such as a skin rash, upload insurance or prescription medication information, and other photo-enabled features.
- Links to helpful resources, including to the most up-to-date information on COVID-19 in Spanish from HHS and where to find the nearest vaccination site.

More Spanish-language resources and data for Latino populations from the Agency for Healthcare Research and Quality can be found here.

PROVIDER RELIEF FUND

Thus far, the largest Provider Relief Fund (PRF) payments have been made to the nation's biggest hospital systems. Fully five of the top 10 recipients of cash were New York City-area hospitals or health systems, receiving some $3.1 billion. The New York and Presbyterian Hospital alone brought in $631 million, topped only by the $1.2 billion that went to the New York City Health and Hospitals Corporation, a group that operates New York City's sprawling system of public hospitals and clinics. Click here for the complete report.

On September 29th, health care providers began being able to apply for $25.5 billion in relief funds, including $8.5 billion in American Rescue Plan resources for providers who serve rural patients covered by Medicare, Medicaid, or the Children's Health Insurance Program and $17 billion for Provider Relief Fund Phase 4 for a broad range of providers with changes in operating revenues and expenses. The application will be open for a period of four weeks. Providers must submit their completed application by the final deadline of October 26th at 11:59 p.m. ET. Providers who have previously created an account in the Provider Relief Fund Application and Attestation Portal HRSA Exit Disclaimer and have not logged in for more than 90 days will need to first reset their password before starting a new application. Click here for more information.

HRSA has made several updates to its Provider Relief Fund guidance. When reporting PRF information through the HRSA portal, these updates could be pertinent; click here for the latest update on 9/13/21. Modified or new information is on: Pages 15-16 – Auditing and Reporting Requirements; Page 21 – Use of Funds; Page 25 – Calculating Eligible Expenses and Lost Revenue; Page 30 – Non- Financial Data.

NEW SURPRISE BILLING RULE

On September 30th, the Department of Health and Human Services (HHS) announced a third rule on surprise billing. The new rule will aim to: take patients out of the middle of payment disputes, provide a transparent process to settle out-of-network (OON) rates between providers and payers, and outline requirements for health care cost estimates for uninsured (or self-pay) individuals. The rule also includes a payment dispute resolution process for uninsured or self-pay patients. HHS, in coordination with the Departments of Labor (DOL), Treasury, and Office of Personnel Management (OPM) will certify independent dispute resolution entities that will be conducting payment determinations on a rolling basis, with a certification deadline of November 1st. The full rule, which will go into effect on January 1, 2022, can be found here. A New York Times article on the rule can be found here.

SUPREME COURT UPCOMING SESSION

The Supreme Court announced its schedule for upcoming cases this fall and included the hospital suit against CMS over the 340B payment cuts under the outpatient payment system. After over four years, this could be the final say in whether HHS does indeed have the authority to cut payments to entities that receive savings under the drug discount program. In another development, HRSA referred to the HHS Office of Inspector General a case in which six drug manufacturers violated statutory 340B Program requirements by refusing to sell, without restriction, covered

outpatient drugs at 340B prices to covered entities that dispense medications through contract pharmacy arrangements. The OIG will investigate and determine if the manufacturers were indeed in violation and if so, fine the companies for refusing to comply. The determination of the OIG could impact the pending court cases underway on the contract pharmacy issue. For the Supreme Court schedule, click here, and for the notice from HRSA, click here.

PRICE TRANSPARENCY

Several Members of both the House and Senate last week sent letters to HHS encouraging the agency to increase penalties for hospitals that are not complying with the price transparency regulations. According to a new study from Georgetown University, many hospitals that have posted the data hide it from web search engines or provide it in a format that makes analysis difficult. The researchers suggest increasing fines, requiring uniform data from all facilities, and asking hospitals to display their commercial and Medicare rates side-by-side. House Energy and Commerce Committee Chairman Frank Pallone (D-NJ) and Ranking Member Cathy McMorris Rodgers (R-WA) sent a letter supporting "significantly increasing potential penalties on noncompliant hospitals," and "applaud the agency's commitment to increasing price transparency." Senate Finance Committee Chairman Ron Wyden (D-OR) sent a letter to CMS also praising the concept of increased penalties, and Senators Mike Braun (R-IN) and Maggie Hassan (D-NH) teamed up on a letter to the agency urging them to "ensure that Americans have access to the most transparent and up-to-date prices." Click here for the report, here for the Pallone/Rogers letter, here for the Wyden letter, and here for the Braun/Hassan letter.

MEDICARE & MEDICAID INDUSTRY WEBINAR ON INNOVATION

On October 6th, the Alliance for Health Policy held a webinar with Dr. Elizabeth Fowler, Director of the Center for Medicare and Medicaid Innovation (CMMI). Dr. Fowler said that CMMI's strategy at this point has three areas of focus: advancing health equity; driving accountable care; and working with partners such as other payers, Medicaid agencies, and purchasers to achieve health transformation. The Biden Administration has a goal of 2030 to get all Medicare beneficiaries into a care relationship with a provider that's accountable for the total cost of care and quality.

Right now, CMMI has 28 payment models running concurrently. They have learned that, with so many models, they are creating opposing incentives. Thus, model participants must consider and manage some of the interactions between the models. At this point, they are talking about going to fewer models that have a broader impact across the health care system. Dr. Fowler stressed the importance of engaging multiple players into payment models. She praised Maryland and Vermont, which have initiated all-payer models in their Medicaid programs.

One of the Biden Administration's top priorities is advancing health equity. CMMI has several Medicaid models in place addressing this, specifically regarding maternal care, children, and rural areas. Dr. Fowler talked about the importance of addressing social determinants of health (SDOH) in all payment models, rather than creating stand-alone models on that topic. She stressed the importance of collecting sufficient appropriate data to determine the full and actual impacts of these models both overall and on how well they address SDOH and health equity.

Dr. Fowler spoke about her support for making at least some models mandatory in order to broaden the kinds of providers who participate. At the same time, she wants to move away from models that focus on only one kind of care or illness. Instead, models will seek to cover more, and all of the models should be better coordinated with each other. Dr. Fowler said that CMMI and the government overall must do more to ensure the various models are aligned in order to decrease the administrative burdens providers face with their participation.

National Academy of Medicine Climate Action

On September 28th, the National Academy of Medicine kicked off its "Action Collaborative on Decarbonizing the Healthcare Sector" with a webcast joined by HHS, the American Hospital Association, American Medical Association, and more. The "Collaborative" is made up of 50 HHS, industry, trade and advocacy officials, who will work to make near-term policy recommendations to reduce the industry's considerable carbon footprint, i.e., nine percent of total US greenhouse gas emissions. The Collaborative is co-chaired by the newly formed HHS Office of Climate Change and Health Equity (OCCHE). More information on the program and the webcast participants can be found here.

US Treasury to Start Reclaiming Rental Aid Funds

On October 4th, the US Department of the Treasury announced that cities, states, and local governments will not trigger the statutory deadline (Sept. 30) for claw backs on rental aid if they submit an improvement plan by November 15th. Under the law, Treasury could start reclaiming funding for rental aid from local governments that used less than 65% of their received allocation. The Emergency Rental Assistance Program (ERAP) rollout has been a frustration for both parties in Congress. The reallocation guidance is here, and a letter from Deputy Secretary Adeyemo to ERAP grantees about the reallocation guidance is here.

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate Bridget E. McGowan Associate

October 18, 2021

LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

General Update

Friday, September 10, marked the last day of the first year of the 2021-22 Legislative Session. The Legislature sent 836 bills to the Governor's desk at the end of session. By the bill signing deadline of October 10, the Governor signed 770 of those bills and vetoed only 66.

The Legislature remains on interim recess through the fall. Session will reconvene in January, where Legislators will return to Sacramento to introduce new legislation and continue work on two-year bills. Below is an update on the bills CalOptima followed closely this session.

Legislation of Interest

AB 342 (Gipson) - Coverage of Colorectal Screening. This bill requires health plans to cover colorectal cancer screening without cost sharing as well as the colonoscopy that is required after a positive result. The California Health Benefits Review Program (CHBRP) indicates that this will cover 3.8 million enrollees statewide and result in a net increase in expenditures of 0.001%.

Patient advocacy and life science organizations supported the bill and health plans opposed. The bill passed out of the Legislature without any No votes and was signed by the Governor on October 1.

AB 361 (R. Rivas) – Open Meetings: Teleconference. This bill would require a local agency to use teleconferencing without complying with the Brown Act when holding a meeting to declare or ratify a local emergency when state/local health officials have required or recommended social distancing. The bill would require that teleconferenced meetings provide notice of the meeting, post agendas, and means for public comment. Further, the bill prohibits local bodies from requiring public comment in advance of the meeting and requires the body to make a series of findings related to the emergency 30 days after each meeting and every 30 days thereafter. The bill has an urgency clause so that it will take effect immediately once signed.

The Governor signed this bill into law on September 16. Because the existing Brown Act Executive Order expired on September 30, the Governor also issued an Executive Order to make the provisions of AB 361 effective October 1, so the two standards do not conflict.

AB 369 (Kamlager) - Medi-Cal for Persons Experiencing Homelessness. This measure requires the Department of Health Care Services (DHCS) to implement a Medi-Cal presumptive eligibility (PE) enrollment process for persons experiencing homelessness (PEH). The program establishes a single streamlined paper and electronic application for Medi-Cal and Covered

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www.egrslobby.com

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California to indicate if applicants are experiencing homelessness. Medi-Cal fee-for-service (FFS) and a Medi-Cal managed care (MCMC) plan are mandated to reimburse Medi-Cal providers for providing covered services that are otherwise reimbursable to the Medi-Cal provider, but that are provided off the premises of the Medi-Cal provider's office. Medi-Cal providers are authorized to issue a temporary Medi-Cal benefits identification card to a PEH who is a Medi-Cal beneficiary.

AB 369 was vetoed by the Governor, who cited programs like Medi-Cal's presumptive eligibility program, provider reimbursement for street-based services, the role of Medi-Cal Managed Care Plans and CalAIM as justification for the veto. As CalAIM is being implemented, he noted that he is directing DHCS to identify and close any interim gaps to serving PEH.

AB 523 (Nazarian) - PACE. This bill requires DHCS to make permanent changes in the PACE program that DHCS instituted, on or before January 1, 2021, in response to COVID-19. The changes include:

- Authorizing PACE organizations to use telehealth to conduct eligibility assessments for enrollment in the PACE program or for service modifications.
- Requiring PACE organizations to collect and document a verbal agreement of enrollment in lieu of the participant signature. Requires PACE organizations to document the verbal agreement and obtain a written signature within 14 days of submitting the enrollment agreement.
- Prohibiting a PACE organization that exclusively serves PACE participants from being required to provide all nursing services at the PACE center.
- Requiring the PACE organizations to have the flexibility to determine how to provide nursing services to participants
- Authorizing services to be provided via telehealth or other remote methods.
- Requiring PACE organizations to have the flexibility to use a broker for marketing, in accordance with existing federal regulations. Also, authorizes PACE organizations to use individuals and entities to market on their behalf if they have been trained
- Authorizing a discharge planner at a PACE referral source to ask the patient or patient representative if they would prefer to be contacted by a PACE organization.
- Requiring a discharge planner to document if a patient or patient representative consents to being contacted by a PACE organization. Also, authorizes a discharge planner to notify the PACE organization the patient or patient consents to being contacted.

This bill passed with a unanimous vote of the Legislature but was vetoed by the Governor.

SB 221 (Wiener) - Timely Access to Care. This bill codifies existing timely access to care standards for health plans and health insurers and applies these requirements to Medi-Cal managed care plans. In addition, the bill adds a standard for non-urgent follow-up appointments for nonphysician mental health care or substance use disorder providers that is within 10 business days of the prior appointment. Finally, the bill prohibits contracting providers and employees from being disciplined for informing patients about timely access standards.

SB 221 passed 76-0 in the Assembly and 35-1 in the Senate and was signed into law on October 8.

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SB 365 (Cabellero) - E-Consult Service. This measure requires an e-consult service to be reimbursable under the Medi-Cal program for an enrolled provider, including a federally qualified health center (FQHC) or rural health clinic (RHC). An "e-consult service" means an interprofessional health record assessment and management service initiated by a treating or requesting provider and delivered by a consultative provider, including a written report to the patient's treating or requesting provider.

The bill was vetoed by the Governor, noting inconsistencies with the definition of e-consult with federal law regarding reimbursement.

SB 510 (Pan) - COVID-19 Cost Sharing. This bill would require health care service plans and disability insurers to cover, without prior approval or cost sharing, the costs for COVID-19 testing and health care services related to the testing for COVID-19, or a future disease when declared a public health emergency by the Governor.

The bill had an urgency clause (2/3 vote) when it came up for a vote on the Assembly floor in the last week of session and failed to garner the 54 votes needed to pass. Because of this, the author removed the urgency clause, and when the bill was brought up again on a majority vote, it reached 55 votes. The bill then passed out of the Senate on a concurrence vote and was signed into law on October 8.

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2021–22 Legislative Tracking Matrix

COVID-19 (CORONAVIRUS)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4735 Axne **S. 2493 Bennet**	**Provider Relief Fund Deadline Extension Act:** Would delay the deadline by which providers must spend any funds received from the Provider Relief Fund — created in response to the COVID-19 pandemic — until the end of 2021 or the end of the COVID-19 public health emergency, whichever occurs later. Funds that are unspent by any deadline must be repaid to the U.S. Department of Health and Human Services (HHS). ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima's contracted providers.*	**07/28/2021** Introduced; referred to committees	CalOptima: Watch
SB 510 Pan	**Disease Testing and Vaccination Coverage:** Requires a health plan to cover COVID-19 diagnostic and screening testing as well as vaccinations provided by an in-network or out-of-network provider, without cost sharing or prior authorization requirements, during a public health emergency. Out-of-network claims must be reimbursed at the prevailing market rate, as determined by future guidance. This bill applies these requirements retroactively from the beginning of the COVID-19 public health emergency as well as to any future diseases causing a public health emergency. ***Potential CalOptima Impact:*** *Reimbursement for all in-network and out-of-network provider claims for COVID-19 testing and vaccinations, retroactive to March 4, 2020.*	**10/08/2021** Signed into law	CalOptima: Watch CAHP: Oppose Unless Amended LHPC: Oppose

BEHAVIORAL HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1914 DeFazio **S. 764 Wyden**	**Crisis Assistance Helping Out On The Streets (CAHOOTS) Act:** Would allow State Medicaid programs to provide 24/7 community-based mobile crisis intervention services — under a State Plan Amendment or waiver — for those experiencing a mental health or substance use disorder crisis. Would provide states a 95% Federal Medical Assistance Percentage (FMAP) to cover such services for three years as well as a total of $25 million in planning grants. ***Potential CalOptima Impact:*** *Subject to further action by the California Department of Health Care Services (DHCS), increased behavioral health and substance use disorder services to CalOptima's Medi-Cal members.*	**03/16/2021** Introduced; referred to committees	**08/05/2021** CalOptima: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 221 Wiener	**Timely Access to Behavioral Health Follow-Up Care:** Codifies current timely access standards requiring health plans to ensure that contracted providers and health networks schedule initial appointments within specified time frames of a beneficiary's request. Beginning July 1, 2022, expands current standards to also require follow-up appointments with a non-physician mental health or substance use disorder provider to be scheduled within 10 business days of a previous appointment related to an ongoing course of treatment — in alignment with the current time frame for the initial appointment. ***Potential CalOptima Impact:*** *Increased monitoring of behavioral health appointments; arrangement and payment of out-of-network coverage when timely access is not ensured; additional contracting with behavioral health providers.*	**10/08/2021** Signed into law	CalOptima: Watch

BUDGET

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 128 Ting **AB 161 Ting** **AB 164 Ting** **SB 129 Skinner**	**Budget Act of 2021**[1, 2]**:** Makes appropriations for the government of the State of California for FY 2021–22. Total spending is $262.6 billion, of which $196.4 billion is from the General Fund. Key initiatives related to health care include: ■ Behavioral health services for youth ■ California Advancing and Innovating Medi-Cal (CalAIM) ■ COVID-19 response ■ Homelessness ■ Medi-Cal eligibility expansion to adults ages 50 years and older, regardless of immigration status ■ Medi-Cal Rx ■ New and reinstated Medi-Cal covered benefits ■ Telehealth	**07/16/2021** Signed into law	CalOptima: Watch
AB 133 Committee on Budget	**Health Trailer Bill I**[1, 2]**:** Consolidates and enacts certain trailer bill language to implement health-related policies funded by the FY 2021–22 state budget. Key initiatives include: ■ Behavioral health services for youth ■ CalAIM ■ Elimination of asset consideration for Medi-Cal eligibility ■ Health information exchange framework ■ Medi-Cal eligibility expansion to adults ages 50 years and older, regardless of immigration status ■ Medi-Cal eligibility extension for postpartum individuals ■ New and reinstated Medi-Cal covered benefits ■ Proposition 56 supplemental payments ■ Telehealth	**07/27/2021** Signed into law	CalOptima: Watch

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Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 171 Committee on Budget and Fiscal Review	**Health Trailer Bill II[1, 2]:** Extends current network adequacy requirements for Medi-Cal managed care plans, including time and distance standards, from January 1, 2022, to January 1, 2023. Also requires DHCS to complete an analysis by January 1, 2024, to determine whether there is sufficient network adequacy to add housing support services as a covered Medi-Cal benefit. Finally, requires DHCS to expand Medi-Cal home- and community-based services (HCBS), authorized by CMS under the American Rescue Plan Act of 2021, to include the following new initiatives: ■ Housing and Homelessness Incentive Program ■ Community Based Residential Continuum Pilots ■ CalAIM funds for HCBS and homeless providers	**09/23/2021** Signed into law	CalOptima: Watch

[1] The potential CalOptima impacts of state budget legislation are included in the Analysis of the Enacted Budget that follows the Legislative Tracking Matrix.

[2] Because CalAIM was included in state budget legislation, separate CalAIM policy bills are no longer required.

COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 56 Biggs	**Patient Access to Medical Foods Act:** Would expand the federal definition of medical foods to include food prescribed as a therapeutic option when traditional therapies have been exhausted or may cause adverse outcomes. Effective January 1, 2022, medical foods, as defined, would be covered by private health insurance providers and federal public health programs, including Medicare, TRICARE, Children's Health Insurance Program (CHIP) and Medicaid, as a mandatory benefit. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima's lines of business.*	**01/04/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 1118 Dingell	**Medicare Hearing Aid Coverage Act of 2021:** Effective January 1, 2022, would require Medicare Part B coverage of hearing aids and related examinations. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly (PACE).*	**02/18/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 4187 Schrier	**Medicare Vision Act of 2021:** Effective January 1, 2024, would require Medicare Part B coverage of vision services, including eyeglasses, contact lenses, routine eye examinations and fittings. ***Potential CalOptima Impact:*** *New covered benefits for CalOptima OneCare and Program of All-Inclusive Care for the Elderly (PACE).*	**06/25/2021** Introduced; referred to committees	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4311 Doggett **S. 2618 Casey**	**Medicare Dental, Vision, and Hearing Benefit Act of 2021:** Effective no sooner than January 1, 2022, would require Medicare Part B coverage of the following benefits: ■ Dental: Routine dental cleanings and examinations, basic and major dental services, emergency dental care, and dentures ■ Vision: Routine eye examinations, eyeglasses, contact lenses and low vision devices ■ Hearing: Routine hearing examinations, hearing aids and related examinations The Senate version would also increase the Medicaid FMAP for hearing, vision and dental services to 90%. ***Potential CalOptima Impact:*** *New covered benefits for CalOptima OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly (PACE); higher federal funding rate for current Medi-Cal benefits.*	**07/01/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 4650 Kelly, R.	**Medicare Dental Coverage Act of 2021:** Effective January 1, 2025, would require Medicare Part B coverage of dental and oral health services, including routine dental cleanings and examinations, basic and major dental treatments, and dentures. ***Potential CalOptima Impact:*** *New covered benefits for CalOptima OneCare and Program of All-Inclusive Care for the Elderly (PACE).*	**07/22/2021** Introduced; referred to committees	CalOptima: Watch
SB 48 Limón	**Annual Cognitive Health Assessment:** Adds annual cognitive health assessments as a covered Medi-Cal benefit for beneficiaries ages 65 or older in order to identify signs of Alzheimer's disease and dementia. Assessments are not covered for beneficiaries who already receive similar assessments as part of an annual wellness visit covered by Medicare. ***Potential CalOptima Impact:*** *New CalOptima Medi-Cal benefit for annual cognitive health assessments for nearly 102,000 members ages 65 or older. As a new benefit, utilization and costs are unknown.*	**10/04/2021** Signed into law	CalOptima: Watch
SB 65 Skinner	**California Momnibus Act:** No later than April 1, 2022, requires DHCS to convene a workgroup to support implementation of the Medi-Cal doula benefit enacted by the FY 2021–22 state budget. The workgroup, consisting of doulas, providers, health plans, counties and advocates, will focus on ensuring beneficiary access and awareness, adequate doula workforce size and training, and timely payment for services. ***Potential CalOptima Impact:*** *Increased guidance and preparation for covering the doula benefit; increased utilization of doula services by CalOptima Medi-Cal members.*	**10/04/2021** Signed into law	CalOptima: Watch
SB 306 Pan	**Sexually Transmitted Disease (STD) Home Test Kits:** Requires health plans to provide coverage and reimbursement for at-home STD test kits and any associated laboratory fees. ***Potential CalOptima Impact:*** *New CalOptima Medi-Cal benefit for at-home STD test kits ordered by an in-network or out-of-network provider, without prior authorization. As a new benefit, utilization and costs are unknown.*	**10/04/2021** Signed into law	CalOptima: Watch CAHP: Oppose

MEDI-CAL OPERATIONS AND ADMINISTRATION

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1738 Dingell **S. 646 Brown**	**Stabilize Medicaid and CHIP Coverage Act of 2021:** Would provide 12 months of continuous eligibility and coverage for any Medicaid or CHIP beneficiary. ***Potential CalOptima Impact:*** *Increased number of CalOptima's Medi-Cal members.*	**03/10/2021** Introduced; referred to committees	CalOptima: Watch ACAP: Support
AB 361 Rivas	**Extension of Brown Act Flexibilities:** Effective immediately upon the Governor's signature, extends temporary Brown Act flexibilities — enacted by the Governor in response to the COVID-19 public health emergency — that allow remote participation in meetings of a local public agency. Previously set to expire on September 30, 2021, these flexibilities are now permitted during any state of emergency that threatens the health and safety of meeting attendees. ***Potential CalOptima Impact:*** *Continued ability for members of CalOptima's Board of Directors and advisory committees to participate in meetings by teleconference during the COVID-19 public health emergency.*	**09/16/2021** Signed into law	CalOptima: Watch LHPC: Support
AB 1082 Waldron	**California Health Benefits Review Program (CHBRP) Extension:** Extends current authorization for the University of California to administer CHBRP, which provides independent analyses of proposed state legislation regarding new health benefits, from July 1, 2022, until July 1, 2027. To fully fund CHBRP, the bill also increases the total annual fee charged to health plans and insurers from $2 million to $2.2 million, beginning July 1, 2022. ***Potential CalOptima Impact:*** *Increased annual fee assessed to CalOptima; continued availability of CHBRP analyses.*	**10/06/2021** Signed into law	CalOptima: Watch CAHP: Support In Concept

OLDER ADULT SERVICES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1868 Yarmuth	**Extension of Medicare Sequestration Moratorium:** Extends the moratorium on automatic, across-the-board 2% spending cuts to Medicare payments. The moratorium, which was set to expire on March 31, 2021, now ends on December 31, 2021. ***Potential CalOptima Impact:*** *Continued federal capitation payments to CalOptima OneCare, OneCare Connect and PACE.*	**04/14/2021** Signed into law	CalOptima: Watch
H.R. 4131 Dingell **S. 2210 Casey**	**Better Jobs Better Care Act:** Would make permanent the enhanced 10% FMAP for Medicaid HCBS enacted by the American Rescue Plan Act of 2021. Would also provide states with $100 million in planning grants to develop HCBS infrastructure and workforces. Additionally, would make permanent spousal impoverishment protections for those receiving HCBS. ***Potential CalOptima Impact:*** *Continuation of current federal funding rate for HCBS; expansion of HCBS opportunities.*	**06/24/2021** Introduced; referred to committees	CalOptima: Watch NPA: Support

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Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4941 Blumenauer	**PACE Part D Choice Act of 2021:** 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 Impact:*** *Increased enrollment into CalOptima PACE by Medicare-only beneficiaries due to decreased out-of-pocket costs.*	**08/06/2021** Introduced; referred to committees	CalOptima: Watch NPA: Support
S. 1162 Casey	**PACE Plus Act:** Would increase the number of PACE programs nationally by making it easier for states to adopt PACE as a model of care and providing grants to organizations to start PACE centers or expand existing PACE centers. Would incentivize states to expand the number of seniors and people with disabilities eligible to receive PACE services beyond those deemed to require a nursing home level of care. Would provide states a 90% FMAP to cover the expanded eligibility. ***Potential CalOptima Impact:*** *Subject to further DHCS authorization, expanded eligibility for CalOptima PACE; additional federal funding to expand the service area of a current PACE center or to establish a new PACE center(s).*	**04/15/2021** Introduced; referred to committee	CalOptima: Watch CalPACE: Support NPA: Support
AB 523 Nazarian	**Permanent PACE Flexibilities:** Would have permanently extended most flexibilities granted to PACE organizations during the COVID-19 public health emergency, including those relating to telehealth services, verbal agreements followed with in-person signatures, Adult Day Health Center home-based services and discharge planning. ***Potential CalOptima Impact:*** *Would have continued most flexibilities adopted by CalOptima PACE during the COVID-19 pandemic.*	**10/06/2021** Vetoed	**06/03/2021** CalOptima: Support CalPACE: Support/ Sponsor

PROVIDERS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 365 Caballero	**Medi-Cal Provider Electronic Consultation (E-Consult) Service:** Would have allowed provider-to-provider e-consult services to be reimbursable to all requesting and consulting Medi-Cal providers, including Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) providers. The e-consult could have included assessing health records, providing feedback and/or recommending a further course of action. ***Potential CalOptima Impact:*** *Would have expanded a reimbursable service for all CalOptima Medi-Cal providers, including FQHCs.*	**10/06/2021** Vetoed	CalOptima: Watch LHPC: Support

SOCIAL DETERMINANTS OF HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 379 Barragan **S. 104 Smith**	**Improving Social Determinants of Health Act of 2021:** Would require the Centers for Disease Control and Prevention (CDC) to establish a social determinants of health (SDOH) program to coordinate activities to improve health outcomes and reduce health inequities. CDC would be required to consider SDOH in all relevant grant awards and other activities, as well as issue new grants of up to $50 million to health agencies, nonprofit organizations and/or institutions of higher education to address or study SDOH. ***Potential CalOptima Impact:*** *Increased availability of federal grants to address SDOH.*	**01/21/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 943 McBath **S. 851 Blumenthal**	**Social Determinants for Moms Act:** Would require HHS to convene a task force to coordinate federal efforts on social determinants of maternal health as well as award grants to address SDOH, eliminate disparities in maternal health and expand access to free childcare during pregnancy-related appointments. Would also extend postpartum eligibility for the Special Supplemental Nutrition Program for Women, Infants, and Children from six months postpartum to two years postpartum. ***Potential CalOptima Impact:*** *Additional federal guidance or requirements as well as increased availability of federal grants to address social factors affecting maternal health.*	**02/08/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 2503 Bustos	**Social Determinants Accelerator Act of 2021:** Would establish the Social Determinants Accelerator Interagency Council to award state and local health agencies up to 25 competitive grants totaling no more than $25 million, as well as provide technical assistance to improve coordination of medical and non-medical services to a targeted population of high-need Medicaid beneficiaries. ***Potential CalOptima Impact:*** *Increased availability of federal grants to address the SDOH of members with complex needs.*	**07/15/2021** Passed House Energy and Commerce Committee's Subcommittee on Health; referred to full Committee	CalOptima: Watch
H.R. 3894 Blunt Rochester	**Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants Act of 2021:** Would require the Centers for Medicare & Medicaid Services (CMS) to update guidance at least once every three years to help states address SDOH in Medicaid and CHIP programs. ***Potential CalOptima Impact:*** *Increased opportunities for CalOptima to address SDOH.*	**07/21/2021** Passed House Energy and Commerce Committee; referred to House floor	CalOptima: Watch
H.R. 4026 Burgess	**Social Determinants of Health Data Analysis Act of 2021:** Would require the Comptroller General of the United States to submit a report to Congress outlining the actions taken by HHS to address SDOH. The report would include an analysis of interagency efforts, barriers and potential duplication of efforts as well as recommendations on how to foster private-public partnerships to address SDOH. ***Potential CalOptima Impact:*** *Increased opportunities for CalOptima to address SDOH.*	**07/21/2021** Passed House Energy and Commerce Committee; referred to House floor	CalOptima: Watch

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Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 369 Kamlager	**Presumptive Eligibility and Street Medicine for Homeless Individuals:** Would have expanded Medi-Cal presumptive eligibility (PE) and street medicine for individuals experiencing homelessness. Specifically, would have: ■ Applied PE, with full-scope benefits and without share of cost, to individuals experiencing homelessness. ■ Allowed any Medi-Cal provider to determine PE and issue a temporary Medi-Cal card. ■ Allowed Medi-Cal providers to deliver any Medi-Cal benefit, including primary, specialist and laboratory services, outside of a medical facility. ■ Prohibited plans from requiring referrals or prior authorizations for individuals experiencing homelessness. ■ Added a field on the Medi-Cal application to indicate homelessness. ■ Required DHCS to deduct capitation payments if a plan did not provide services to a person indicating homelessness within 60 days of Medi-Cal enrollment. ***Potential CalOptima Impact:*** *Could have increased the number of CalOptima Medi-Cal members; could have increased access to services for homeless members but negatively impacted care coordination; could have increased payments to providers; would have required modified utilization management procedures for homeless members; could have decreased DHCS capitation payments to CalOptima for homeless members.*	**10/08/2021** Vetoed	CalOptima: Watch LHPC: Oppose Unless Amended

TELEHEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 366 Thompson, M.	**Protecting Access to Post-COVID-19 Telehealth Act of 2021:** Would allow HHS to waive or modify any telehealth service requirements in the Medicare program during a national disaster or public health emergency and for 90 days after one is terminated. Would also permit Medicare reimbursement for telehealth services provided by an FQHC or RHC, as well as allow patients to receive telehealth services in the home without restrictions. ***Potential CalOptima Impact:*** *Continuation and expansion of certain telehealth flexibilities allowed during the COVID-19 pandemic for CalOptima OneCare, OneCare Connect and PACE.*	**01/19/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 2166 Sewell	**Ensuring Parity in MA and PACE for Audio-Only Telehealth Act of 2021:** Would require CMS to include audio-only telehealth diagnoses in the determination of risk adjustment payments for Medicare Advantage (MA) and PACE plans during the COVID-19 public health emergency. ***Potential CalOptima Impact:*** *For CalOptima OneCare, OneCare Connect and PACE, members' risk scores and risk adjustment payments would accurately reflect diagnoses.*	**03/23/2021** Introduced; referred to committees	**08/05/2021** CalOptima: Support ACAP: Support NPA: Support

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Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 2903 Thompson, M. **S. 1512 Schatz**	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2021:** Would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Specifically, would: ■ Remove all geographic restrictions for telehealth services ■ Allow beneficiaries to receive telehealth in their own homes, in addition to other locations determined by HHS ■ Remove restrictions on the use of telehealth in emergency medical care ■ Allow FQHCs and RHCs to provide telehealth services ***Potential CalOptima Impact:*** *Continuation and expansion of telehealth flexibilities for CalOptima OneCare, OneCare Connect and PACE.*	**04/28/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 3447 Smith, J.	**Permanency for Audio-Only Telehealth Act:** Would permanently extend the following current flexibilities, which have been temporarily authorized by CMS during the COVID-19 public health emergency: ■ Medicare providers may be reimbursed for providing certain services via audio-only telehealth, including evaluation and management, behavioral health and substance use disorder services, or any other service specified by HHS. ■ Medicare beneficiaries may receive telehealth services at any location, including their homes. ***Potential CalOptima Impact:*** *Permanent continuation of certain telehealth flexibilities for CalOptima OneCare, OneCare Connect and PACE.*	**05/20/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 4058 Matsui **S. 2061 Cassidy**	**Telemental Health Care Access Act of 2021:** Would remove the requirement that Medicare beneficiaries be seen in-person within six months of being treated for behavioral health services via telehealth. ***Potential CalOptima Impact:*** *For CalOptima OneCare and OneCare Connect, decreased in-person behavioral health encounters and increased telehealth behavioral health encounters.*	**06/22/2021** Introduced; referred to committees	CalOptima: Watch
S. 150 Cortez Masto	**Ensuring Parity in MA for Audio-Only Telehealth Act of 2021:** Would require CMS to include audio-only telehealth diagnoses in the determination of risk adjustment payments for MA plans during the COVID-19 public health emergency ***Potential CalOptima Impact:*** *For CalOptima OneCare and OneCare Connect, members' risk scores and risk adjustment payments would accurately reflect diagnoses.*	**02/02/2021** Introduced; referred to committee	CalOptima: Watch ACAP: Support NPA: Support

YOUTH SERVICES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 66 Buchanan	**Comprehensive Access to Robust Insurance Now Guaranteed (CARING) for Kids Act:** Would permanently extend authorization and funding of CHIP and associated programs, including the Medicaid and CHIP express lane eligibility option, which enables states to expedite eligibility determinations by referencing enrollment in other public programs. ***Potential CalOptima Impact:*** *Continuation of current federal funding and eligibility requirements for CalOptima's Medi-Cal members eligible under CHIP.*	**01/04/2021** Introduced; referred to committee	CalOptima: Watch
H.R. 1390 Wild **S. 453 Casey**	**Children's Health Insurance Program Pandemic Enhancement and Relief (CHIPPER) Act:** Would retroactively extend CHIP's temporary 11.5% FMAP increase, enacted by the HEALTHY KIDS Act (2018), from September 30, 2020, until September 30, 2022, to meet increased health care needs during the COVID-19 public health emergency. ***Potential CalOptima Impact:*** *Increased federal funds for CalOptima's Medi-Cal members eligible under CHIP.*	**02/25/2021** Introduced; referred to committees	CalOptima: Watch
SB 682 Rubio	**Childhood Chronic Health Conditions:** Would have required the California Health and Human Services Agency to convene an advisory workgroup to develop and implement a plan that reduces racial disparities in children with chronic health conditions by 50% by 2030. Chronic conditions could have included asthma, diabetes, depression and vaping-related diseases. ***Potential CalOptima Impact:*** *DHCS could have required CalOptima to incorporate new interventions, quality measures and/or reporting requirements.*	**10/04/2021** Vetoed	CalOptima: Watch

Two-Year Bills

The following bills did not meet the deadline to be passed by both houses of the State Legislature. These are now considered two-year bills and are eligible for reconsideration in 2022:

- AB 4 (Arambula)
- AB 32 (Aguiar-Curry)
- AB 58 (Salas)
- AB 71 (Rivas, L.)
- AB 112 (Holden)
- AB 114 (Maienschein)
- AB 393 (Reyes)
- AB 454 (Rodriguez)
- AB 470 (Carrillo)
- AB 540 (Petrie-Norris)
- AB 685 (Maienschein)
- AB 797 (Wicks)
- AB 552 (Quirk-Silva)
- AB 563 (Berman)
- AB 586 (O'Donnell)
- AB 671 (Wood)
- AB 685 (Maienschein)
- AB 797 (Wicks)
- AB 822 (Rodriguez)
- AB 862 (Chen)
- AB 875 (Wood)
- AB 882 (Gray)
- AB 935 (Maienschein)
- AB 942 (Wood)
- AB 1050 (Gray)
- AB 1083 (Nazarian)
- AB 1107 (Boerner Horvath)
- AB 1117 (Wicks)
- AB 1131 (Wood)
- AB 1132 (Wood)
- AB 1160 (Rubio)
- AB 1162 (Villapadua)
- AB 1254 (Gipson)
- AB 1372 (Muratsuchi)
- AB 1400 (Kalra; Lee; Santiago)
- SB 17 (Pan)
- SB 56 (Pan)
- SB 245 (Gonzalez)
- SB 250 (Pan)
- SB 256 (Pan)
- SB 279 (Pan)
- SB 293 (Limon)
- SB 316 (Eggman)
- SB 371 (Caballero)
- SB 508 (Stern)
- SB 523 (Leyva)
- SB 562 (Portantino)
- SB 773 (Roth)

*Information in this document is subject to change as bills proceed through the legislative process.

ACAP: Association for Community Affiliated Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: October 11, 2021

2021 Federal Legislative Dates

January 3	117th Congress, First Session convenes
March 29–April 9	Spring recess
August 2–27	Summer recess for House
August 9–September 10	Summer recess for Senate
December 10	First Session adjourns

2021 State Legislative Dates*

**Due to COVID-19, 2021 State Legislative dates have been modified*

January 11	Legislature reconvenes
February 19	Last day for legislation to be introduced
March 25–April 4	Spring recess
April 30	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in their house
May 7	Last day for policy committees to hear and report to the floor any non-fiscal bills introduced in their house
May 21	Last day for fiscal committees to hear and report to the floor any bills introduced in their house
June 1–4	Floor session only
June 4	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 14	Last day for policy committees to hear and report bills to fiscal committees or the floor
July 16–August 15	Summer recess
August 27	Last day for fiscal committees to report bills to the floor
August 30–September 10	Floor session only
September 3	Last day to amend bills on the floor
September 10	Last day for bills to be passed; final recess begins upon adjournment
October 10	Last day for Governor to sign or veto bills passed by the Legislature

Sources: 2021 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima

CalOptima 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 provide members with access to quality health care services delivered in a cost-effective and compassionate manner. We provide coverage through four major programs: Medi-Cal, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), OneCare (Medicare Advantage Special Needs Plan) and the Program of All-Inclusive Care for the Elderly (PACE).

FY 2021–22 California State Budget: Analysis of the Enacted Budget

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Overview

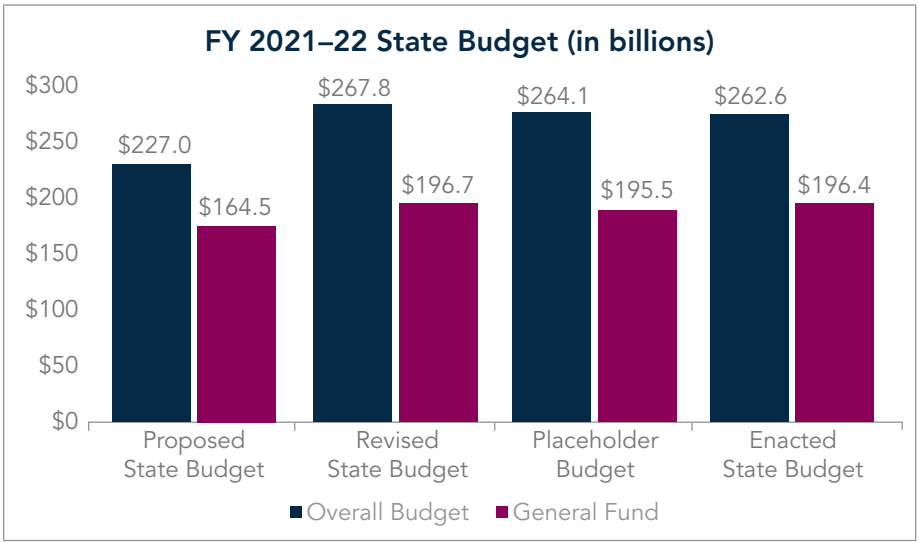
On January 8, 2021, Gov. Gavin Newsom released the Fiscal Year (FY) 2021–22 Proposed State Budget of $227 billion, including $164.5 billion General Fund (GF).[1] After experiencing a $54 billion budget shortfall in the Enacted FY 2020–21 State Budget, the proposed budget estimated $34 billion in budget resiliency, including a $12 billion surplus and $22 billion in budget reserves.

On May 14, 2021, Gov. Newsom announced the Revised State Budget (May Revise) for FY 2021–22. The May Revise proposed a state budget of $267.8 billion, including $196.7 billion GF.[2] With the economy beginning to recover from the COVID-19 pandemic, the May Revise included the *California Comeback Plan*, a budget surplus of $100 billion for the next FY.

To meet the constitutionally obligated deadline to pass a balanced budget, on June 14, 2021, the Senate and Assembly passed the Budget Act of 2021, Assembly Bill (AB) 128, a preliminary state budget for FY 2021–22. The Legislature's Budget includes a spending plan of $264.1 billion, including $195.5 billion GF. This reflects a $3.7 billion decrease in overall spending from the May Revise.

Following negotiations with the Legislature, on June 28, 2021, Gov. Newsom signed into law AB 128 and, on July 12, 2021, Senate Bill 129 followed by AB 133 on July 27. Together, these bills represent the Enacted Budget for FY 2021–22.

Table 1. California State Budget



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Enacted Budget & Key Impacts

The Enacted Budget reflects a total spending plan of $262.6 billion ($196.4 billion GF) for FY 2021–22.

Medi-Cal Budget

The spending plan also increases funding for Medi-Cal and assumes total Medi-Cal enrollment will reach 14.5 million by 2022.

The overall caseload is influenced by the suspension of Medi-Cal eligibility redeterminations, the COVID-19-driven recession and additional data on actual caseload growth.

Key budget initiatives related to health care with a significant impact to CalOptima include:

- Behavioral health services for youth
- California Advancing and Innovating Medi-Cal (CalAIM) proposal
- Medi-Cal eligibility for older adults ages 50 and older, regardless of immigration status

Behavioral Health for Youth

In response to the ongoing COVID-19 pandemic, the Administration and State Legislature have prioritized behavioral health (BH) services for youth ages 25 and younger. The Enacted Budget includes nearly $4.4 billion in funding over five years with several initiatives focusing on care coordination, prevention and access.[4] This includes implementing a $400 million one-time funding incentive plan through Medi-Cal managed care plans (MCPs) to increase the number of preschool and TK-12 students receiving preventive and early intervention BH services at school, beginning no sooner than January 1, 2022.

During calendar year (CY) 2020, **more than 40,000 CalOptima members under the age of 19 utilized BH services** — half of which were diagnosed with severe mental illness and received care through the Orange County Health Care Agency (HCA). If CalOptima opts into the BH incentive program, CalOptima will need to establish the infrastructure to administer Medi-Cal-reimbursable services to students. CalOptima does not currently contract with schools or school districts. This could result in significant administrative changes for CalOptima by requiring increased staff time to administer incentive payments and implement interventions with one or more school districts.

Of note, CalOptima already has an existing MOU with HCA for BH services. It is unknown if a new MOU would need to be established and at what level schools would be integrated into the incentive program. Pending guidance from DHCS, the program may lead to confusion regarding where the member can access services (e.g., school, MCP or HCA), who is responsible for that member, and what role each provider would play. With key details still missing from this proposal, including the allocation of funds, the exact degree of impact remains unclear.

Other funding directed for innovative and preventive youth BH services includes:

- $1.4 billion ($1 billion GF, $100 million Coronavirus Fiscal Recovery Fund, $222 million federal funds, and $105 million Mental Health Services Fund) in 2021-22
- $1.5 billion ($1.4 billion GF and $124 million federal funds) in 2022-23
- $431 million ($300 million GF and $131 million federal funds) in 2023-24 and ongoing[3]

CalAIM

The CalAIM initiative received full funding in the Enacted Budget, with $1.6 billion total funds ($650.7 million GF) for FY 2021–22, $1.5 billion total funds ($812.5million GF) for FY 2023–24, decreasing to $900 million ($480 million GF) by FY 2024-25, ongoing.[4] When compared with the January Proposed Budget, this reflects an increase of $5 billion for FY 2021–22.

Table 2. CalAIM Funding

Cost Category	Enacted Budget
Behavioral Health	$21.8 million
Dental	$113.5 million
Enhanced Care Management	$187.5 million
Incentives	$300 million
In Lieu of Services	$47.9 million
Medically Tailored Meals	$9.3 million
Multipurpose Senior Services Program Carve-out	$1.6 million
Organ Transplant Carve-In	$4.7 million
Population Health Management (PHM)	$315 million
Providing Access and Transforming Health (PATH)	$200 million
Specialty Mental Health Services Carve-Out	-$4.8 million
State Operations Funding	$38.9 million
Transitioning Populations	$401.6 million

Of the CalAIM initiatives, ECM, ILOS and operating a Dual Eligible Special Needs Plan (D-SNP) are projected to have direct impacts to CalOptima, with details to follow.

ECM and ILOS

Building upon the existing Health Homes Program (HHP) delivery system infrastructure, ECM is designed to meet clinical and nonclinical needs of the highest-cost and/or highest-need beneficiaries. This includes members experiencing homelessness, members with complex medical conditions, members unable to self-manage health successfully and may include those enrolled in HHP or Whole Person Care (WPC). ILOS, which is optional for MCPs to offer, also builds upon both HHP and WPC infrastructures as a way to provide flexible wrap-around services as substitutes for other covered services, such as emergency department visits or skilled nursing facility admissions. DHCS has proposed 14 ILOS options, four of which CalOptima will implement in Phase 1. CalOptima has not yet determined which of the remaining ILOS options will be included in Phase 2 and beyond. Of note, CalOptima has begun discussions with HCA and its current ECM providers (health networks) to coordinate implementation efforts and ensure no gaps in services.

Table 2. Phase 1 ILOS Programs (No Sooner Than January 1, 2022)

Housing Transition Navigation Services	Housing Tenancy and Sustaining Services
Housing Deposits	Recuperative Care (Medical Respite)

Table 3. Pending Future ILOS Programs (No Sooner Than July 1, 2022)

Short-Term Post-Hospitalization Housing	Personal Care and Homemaker Services
Respite Services	Environmental Accessibility Adaptations (Home Modifications)
Day Habilitation Programs	Meals/Medically Tailored Meals
Nursing Facility Transition/Diversion to Assisted Living Facilities	Sobering Centers
Community Transition Services/Nursing Facility Transition to a Home	Asthma Remediation

As of June 2021, there are approximately 790 CalOptima members participating in HHP and nearly 5,000 members in WPC. Based on current populations identified in May 2021, **CalOptima projects approximately 34,000 members may be eligible for ECM and/or ILOS**. Additional population projections will be available in the future, pending guidance from DHCS. Of note, recent DHCS guidance directs counties managing a WPC pilot to determine which members should transition to ECM, ILOS or both. If a member is not deemed appropriate for ECM, ILOS or both, that county will continue to manage that individual's care until referred to another service.

With ECM reimbursement rates and the cost of providing ILOS still pending due to unknown utilization levels, CalOptima has budgeted approximately $16 million for FY 2022 in Medi-Cal revenue and expenses for ECM and ILOS. ECM and ILOS are scheduled to be implemented no sooner than January 1, 2022.

D-SNP

To standardize comprehensive care coordination, the Enacted Budget supports the discontinuation of the Cal MediConnect pilot program at the end of CY 2022. DHCS will support mandatory enrollment of dually eligible beneficiaries into managed care and require MCPs to operate a Medicare D-SNP in order to achieve that aligned enrollment.

Therefore, **CalOptima will be required to transition more than 14,000 OneCare Connect members into OneCare, CalOptima's D-SNP,** effective January 1, 2023. Current trends project 250 Orange County residents become dually eligible for Medi-Cal and Medicare each month. Pending further clarification from DHCS, it is unknown how aligned enrollment will be implemented for CalOptima members who become dually eligible on or after January 1, 2023. Of note, there are approximately 75,000 dually eligible seniors in Medicare fee-for-service (FFS) in Orange County. Those individuals will not be required to passively enroll into OneCare and will remain in Medicare FFS unless they elect to enroll in a D-SNP.

Medi-Cal Eligibility Expansion

Older Adults

The Enacted Budget expands Medi-Cal eligibility to those 50 years or older, regardless of immigration status. This was originally proposed in 2019 and paused due to the COVID-19 pandemic. The cost of the expansion is $1.5 billion ($1.3 billion GF) ongoing, including In-Home Supportive Services, effective no sooner than May 1, 2022.[5]

There are an estimated 17,000 Orange County residents ages 55 and older who are undocumented immigrants; another 37,000 are ages 45–54.[6] Of that population, CalOptima staff estimate there are approximately 35,000 individuals ages 50 and older. While those eligible for full-scope Medi-Cal based on federal poverty level (FPL) percentage is unknown, it is estimated that nearly half of those individuals are eligible. Therefore, **CalOptima is projecting approximately 16,000–17,000 new members**.

Pregnant Women and Their Newborn Children

The Enacted Budget includes a 5-year Medi-Cal eligibility expansion program for postpartum individuals and their newborn children, regardless of receiving a formal BH-related diagnosis. This extends eligibility for full-scope Medi-Cal from 60 days to 12 months postpartum and would apply to those with an FPL percentage of 139% to 322%. Effective no sooner than April 1, 2022, the budget includes $90.5 million ($45.3 million GF) in FY 2021–22 and $362.2 million ($181.1 million GF) in FY 2022–23, increasing to $400 million ($200 million GF) until April 2027, to implement the extension.[7]

In 2020, nearly 750 CalOptima members earning 139% to 322% FPL were Medi-Cal-eligible because of their pregnancy. Since this program extends access to full-scope Medi-Cal from 60 days to 12 months postpartum, it is expected that point-in-time membership and utilization of covered services, overall, will increase. However, the total number of unique CalOptima members is projected to remain the same.

Covered Benefits

In addition to introducing the CalAIM proposal, Gov. Newsom proposed that Medi-Cal expand the list of covered benefits and address issues relating to health equity and cultural sensitivity. In response, the Enacted Budget includes three new covered benefits.

- **Continuous Glucose Monitors (CGMs):** $4.9 million ($1.3 million GF) to include CGM devices as a Medi-Cal-covered benefit for those with Type 1 Diabetes, effective January 1, 2022.[8] CalOptima had 6,700 members with Type 1 Diabetes through CY 2020. These members would meet the qualifications to request a CGM device as a new method to manage their Type 1 Diabetes.
- **Doula Care:** $403,000 ($152,000 GF) in FY 2021–22 and approximately $4.4 million ($1.7 million GF) annually to add doula services as a Medi-Cal covered benefit, effective January 1, 2022.[9] While CalOptima is unable to specifically identify members who may become pregnant and use doula services in CY 2021, there were approximately 15,000 members who became pregnant in CY 2020.
- **Dyadic Care:** $800 million to introduce dyadic care as a new statewide Medi-Cal benefit, effective no sooner than July 1, 2022.[10] Similar to Parent-Child Interaction Therapy, currently managed by HCA, dyadic care would provide integrated physical and behavioral health screening and services to the whole family. The goal of providing dyadic care is to improve access to preventive and coordinated care for children, rates of immunization completion, social-emotional health services, developmentally appropriate parenting and maternal mental health. As this is a new covered benefit, CalOptima is unable to determine the exact impact to the plan. However, for CY 2020, 282,000 CalOptima members were 21 years or younger, with approximately 60,000 utilizing BH services. It is projected that children with a BH-related condition may be more likely to use dyadic care.
- **Over the Counter (OTC) Medications:** Reinstates Medi-Cal coverage for adult cold/cough and acetaminophen OTC medications, effective July 1, 2021.[11] Based on utilization prior to being eliminated, reinstating these OTC medications may cost CalOptima approximately $600,000 a year. However, once the pharmacy benefit is carved out of managed care, there will be no cost to CalOptima.

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

COVID-19

California continues to recover from the COVID-19 pandemic-driven recession and public health emergency. As of July 2021, over 3.7 million California residents have contracted COVID-19 and nearly 64,000 people have died.[12] The Enacted Budget highlights the State's ongoing response to the pandemic using state and federal funds, including $27 billion from the American Rescue Plan Act of 2021.

Since the May Revise, the State calculated an additional $122 million in spending related to the vaccine distribution and administration. Therefore, current fiscal impacts to the state include $12.1 billion total costs between FY 2019-20 and 2021–22.[13] This includes costs for contact tracing, testing, vaccine administration and temporary provider reimbursements.

Table 4. COVID-19 Costs to the State[14]

Cost Category	Enacted Budget
Community Engagement	$193.3 million
Contact Tracing and Tracking	$233.1 million
Hospital and Medical Surge	$1.2 billion
Hotels for Health Care Workers	$277.9 million
Housing for the Harvest	$24.2 million
Procurements	$2.9 billion
State Response Operations	$2.3 billion
Statewide Testing	$1.8 billion
Support for Vulnerable Populations	$1.7 billion
Vaccine Distribution and Administration	$1.5 billion

Furthermore, the state will continue to maximize the use of federal funds to support the current public health emergency, currently projected to remain in effect through December 2021. This includes:

- $236.6 billion from the Coronavirus Aid, Relief, and Economic Security Act
- $191.1 billion from the American Rescue Plan Act
- $99.2 billion from the Coronavirus Response and Relief Act
- $74.7 billion from the Paycheck Protection and Health Care Act
- $17.3 billion from the Families First Act
- $8 billion from the Federal Emergency Management Agency (FEMA) Public Assistance Program
- $2.4 billion from the Coronavirus Relief Fund
- $1.6 billion from the Preparedness and Response Act
- $347.7 million from other federal and private funds

Of note, upon the conclusion of the public health emergency, the Enacted Budget includes one-time funding of $73 million ($36.5 million GF) for FY 2021–22 and FY 2022–23 to resume annual Medi-Cal redeterminations.[15]

Homelessness

The State's response with Project Roomkey, and then Project Homekey, was successful at both housing those experiencing homelessness and reducing their risk of contracting COVID-19. The Enacted Budget includes approximately $12 billion for housing and homeless services over the next two FYs, with a goal to end homelessness statewide.[16] This includes $5.8 billion in one-time funds over two years to further support Project Homekey. Initiatives within Project Homekey will also include BH services and housing support for youth, families, and low-income seniors.

It is anticipated that of the 132 units currently available in Orange County through Project Homekey, approximately 80% will house CalOptima members.

Medi-Cal Rx

The Medi-Cal pharmacy (Rx) benefit carve-out will remain carved-in to managed care through the remainder of CY 2021. The Administration anticipates the carve-out will take place no sooner than January 1, 2022. With the current placeholder in the Enacted Budget, the pharmacy carve-out is expected to result in ongoing annual savings of $859 million total funds ($309 million GF). Due to the timing of various Medi-Cal Rx transition impacts, the budget also assumes temporary costs of $32 million total funds ($14 million GF) in FY 2020–21 and $363 million total funds ($134 million GF) in FY 2021–22.[17] The Administration is still discussing an implementation plan and will provide an update within the coming months.

Telehealth

As part of the Administration's proposal, the Enacted Budget includes $151.1 million ($53.3 million GF) for FY 2021–22 to extend telehealth flexibilities implemented during the pandemic.[18] DHCS will consult with stakeholders to establish utilization management protocols for all telehealth services prior to implementation of post-pandemic telehealth services.

Other Medi-Cal Programs

Community Health Workers

$16.3 million ($6.2 million GF), increasing to $201 million ($76 million GF) by FY 2026–27, to add community health workers to the class of health workers who are able to provide services to Medi-Cal beneficiaries, effective January 1, 2022.[19]

Health Information Exchange

$2.5 million GF for the Health and Human Services Agency to lead efforts and stakeholder engagement to build out information exchange capabilities for health and social services programs.[20]

Master Plan for Aging (MPA) Implementation

$3.3 million GF ongoing for the hiring of 20 permanent positions that will provide the Department of Aging with policy, project management and information technology leadership necessary to implement the MPA.[21] Of note, it is still unknown which initiatives will be implemented first.

Regional Center Mobile Crisis Teams

$8 million GF in FY 2021–22, increasing to $11 million GF ongoing in FY 2022–23, for Systemic, Therapeutic, Assessment, Resources and Treatment (START) teams. The START teams provide 24-hour crisis prevention and response services to individuals with intellectual or developmental disabilities.[22]

Next Steps

The Legislature will continue to advance budget trailer bills and policy bills through the legislative process. Bills with funding allocated in the Enacted Budget are likely to be passed and signed into law. The Legislature has until September 10, 2021, to pass legislation, and Gov. Newsom has until October 10, 2021, to either sign or veto that legislation. Additionally, state agencies will begin implementing the policies enacted through the budget, such as CalAIM and the Medi-Cal Rx carve-out. Staff will continue to monitor these polices and provide updates regarding issues that have a significant impact to CalOptima.

About CalOptima

CalOptima, 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 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.

Endnotes

[1] 2021-22 Governor's Budget: Proposed Budget Detail, January 8, 2021
[2] 2021–22 Governor's May Revise Budget Summary, May 14, 2021, Pg. 13
[3] 2021-22 Governor's Enacted Budget Summary, Pg. 83
[4] California State Assembly Floor Report of the 2021-22 Budget, July 15, 2021, Pg. 9
[5] 2021-22 Governor's Enacted Budget Summary, Pg. 69
[6] Profile of the Unauthorized Population: Orange County, CA, Migration Policy Institute, 2018
[7] 2021-22 Governor's May Revise Budget Summary, May 14, 2021, Pg. 96
[8] 2021-22 Governor's Enacted Budget, Department of Health Care Services Enacted Budget Detail
[9] 2021-22 Governor's Enacted Budget Summary, Pg. 70
[10] California State Assembly Floor Report of the 2021-22 Budget, July 15, 2021, Pg. 16
[11] California State Assembly Floor Report of the 2021-22 Budget, July 15, 2021, Pg. 26
[12] State of California COVID-19 Dashboard, July 19, 2021
[13] 2021-22 Governor's Enacted Budget Summary, Pg. 31
[14] 2021-22 Governor's Enacted Budget Summary, Pg. 32
[15] 2021-22 Governor's Enacted Budget Summary, Pg. 71
[16] 2021-22 Governor's Enacted Budget Summary, Pg. 70
[17] 2021-22 Governor's Enacted Budget, Department of Health Care Services Enacted Budget Detail
[18] 2021-22 Governor's Enacted Budget Summary, Pg. 71
[19] 2021-22 Governor's Enacted Budget Summary, Pg. 70
[20] 2021-22 Governor's Enacted Budget Summary, Pg. 84
[21] 22021-22 Governor's Enacted Budget Summar, Pg. 87
[22] 22021-22 Governor's Enacted Budget Summar, Pg. 81

Board of Directors Meeting
November 4, 2021

CalOptima Community Outreach Summary — October and November 2021

Background
CalOptima is committed to serving the community by sharing information with current and potential members and strengthening relationships with community partners. CalOptima accomplishes this by participating in community coalitions, collaborative meetings and advisory groups, supporting our community partners' public activities, and sharing information with current and potential members.

CalOptima's participation in public activities supports:

- Member interaction/enrollment in a CalOptima program
- Branding that promotes community awareness of CalOptima
- Partnerships that increase positive visibility and relationships with community organizations

CalOptima is reviewing recent updates to local, state and federal guidelines to prevent the spread of COVID-19. In the interim, CalOptima continues to participate in public activities via virtual meetings and events, and limited in-person events, providing CalOptima Medi-Cal educational materials and, if criteria are met, providing financial support and/or CalOptima-branded items. (Some exceptions may apply.)

CalOptima Highlight
Note: This late September event is included in this report due to staff report submission deadlines.

For the seventh year in a row, on September 19, CalOptima participated in the Mid-Autumn Moon Festival, organized by Viet America Society. This year's festival attracted the highest attendance on record, drawing approximately 7,400 individuals. After a year and a half of social distancing, families came out to celebrate this cultural event with entertainment provided by well-known Vietnamese artists, youth dance performances, face painting, balloon artists and food trucks. Supervisor Andrew Do, who also serves as Chair of the CalOptima Board of Directors, distributed thousands of mooncakes and lanterns for the children's parade. CalOptima's participation included welcome remarks during the opening ceremony by Chief Executive Officer Richard Sanchez, distribution of lanterns and mooncakes by Thanh-Tam Nguyen, M.D., a CalOptima Medical Director, and a CalOptima hosted resource booth to share information about Medi-Cal programs and services with Vietnamese members and others.

For additional information or questions, please contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

Summary of Public Activities
As of September 21, 2021, CalOptima plans to participate in, organize or convene 54 public activities in October and November. For October, this includes 32 public activities: 26 virtual community/collaborative meetings, 2 community events, 2 community-based organization presentations, 1 Cafecito and 1 Health Network Forum. For November, this includes 22 public activities: 19 virtual community/collaborative meetings, 2 community events, and 1 Health Network Forum.

CalOptima's participation in community meetings throughout Orange County can be found at: https://www.caloptima.org/en/About/CommunityRelations/UpcomingEventsAndMeetings.aspx.

On the following page are more details about CalOptima's participation in community events hosted by community partners and CalOptima-hosted events and meetings:

October 2021			
Date/Time	**Event Title/Location**	**Expected Staff/Volunteer/ Financial Participation**	**Event Type/Audience**
10/1 9 a.m.–10 a.m.	**CalOptima Medi-Cal Spanish Presentation for Willard Intermediate School** Virtual	1 staff member presented.	• Community-based organization presentation • Open to staff and parents
10/6 11 a.m.–3 p.m.	**Fall Festival Resource Fair hosted by Eli Home†** The Eli Home 1175 N. East St., Anaheim	1 staff member attended (in person).	• Health/resource fair • Open to the public
10/9 9 a.m.– 12 p.m.	**Resource Fair hosted by Tustin Area Senior Center†** 200 S. "C" St., Tustin	1 staff member attended (in person) Registration fee: $25 included a resource table at the event.	• Health/resource fair • Open to the public
10/9 1 p.m.– 5 p.m.	**Trans Pride 2021 hosted by LGBTQ Center OC** The Center on 4th 305 E. 4th St., Ste 200, Santa Ana	1 staff member attended (in person) Sponsorship fee: $500 includes CalOptima logo on digital flyers, event webpage and shirt, featured in virtual interactive resource fair, stage recognition, and social media.	• Health/resource fair • Open to the public
10/16 9 a.m.– 12 p.m.	**Out of the Darkness Community Walk hosted by American Foundation for Suicide Prevention†** Hybrid Saddleback Church 1 Saddleback Pkwy., Lake Forest	1 staff member attended. Sponsorship fee: $1,000 included an opportunity to provide a 1-minute pre-recorded program aired during the event livestream, a virtual resource table, resource table at the in-person walk, CalOptima logo placement on event t-shirts and email announcement to registered participants, event registration page with a link to CalOptima's website, a sponsor slide, signage along event route, recognition via social media and 6 complimentary t-shirts for walkers.	• Health/resource fair • Open to the public
10/21 9 a.m.–11 a.m.	**Health Network Forum*** Virtual	At least 10 staff members attended.	• Forum • Open to health and human service providers
10/27 9 a.m.–10:30 a.m.	**Cafecito Meeting*** Virtual	At least 3 staff members attended.	• Steering committee meeting • Open to collaborative members
10/28 10 a.m. –11 a.m.	**CalOptima Medi-Cal Presentation for King Elementary School** Virtual	1 staff member presented.	• Community-based organization presentation • Open to staff and parents

* CalOptima Hosted
† Exhibitor/Attendee

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November 2021			
11/5 9:30 a.m.– 12:30 p.m.	**Annual Alzheimer's Latino Conference hosted by Alzheimer's OC†** Virtual	1 staff member to attend. Sponsorship fee: $1,000 includes an opportunity to provide welcome remarks during the event opening ceremony, acknowledgement in event advertisements (radio, magazine, website and Facebook), placement of CalOptima logo on virtual conference platform and agenda, and a Certificate of Recognition.	• Conference • Open to the public
11/18 9 a.m.–11 a.m.	**Health Network Forum*** Virtual	At least 10 staff members to attend.	• Forum • Open to health and human service providers

These sponsorship request(s) and community event(s) meet the requirements of CalOptima 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.

Endorsements
CalOptima provided zero 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 Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name and Logo. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

* CalOptima Hosted
† Exhibitor/Attendee

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Selecting and Contracting with Kennaday Leavitt PC for Outside General Counsel.

Contacts

Legal Ad Hoc Committee Members
Chair Andrew Do
Vice Chair Clayton Corwin
Director Isabel Becerra

Recommended Action(s)

1. Approve the recommended outside general counsel firm Kennaday Leavitt PC;
2. Authorize the Chief Executive Officer (CEO) to execute a contract with Kennaday Leavitt PC effective November 4, 2021, through October 31, 2022, along with two additional one-year extension options, each exercisable at CalOptima's sole discretion, to serve as general counsel; and
3. Authorize unbudgeted expenditures in an amount up to $1.05 million from existing reserves to fund the contract.

Background

CalOptima is Orange County's ("County") public managed care health plan for County residents who are eligible for Medi-Cal benefits. As a county organized health care system, or "COHS," it is the sole health plan that eligible County residents may have access to receive Medi-Cal program benefits. CalOptima currently arranges for the delivery of Medi-Cal health care services to over 800,000 beneficiaries, and it is anticipated that that number may grow significantly in the coming years. CalOptima also has a Medicare-Medi-Cal product, and a Program of All-Inclusive Care for the Elderly ("PACE") program, that both continue to grow in membership.

Managed care is a complex, expensive and challenging business. Managed care plans offering predominantly Medi-Cal programs, as well as dual-eligible and PACE programs, are even more complicated to operate because of substantial regulation by both the state and federal governments. Managed Medi-Cal plans that are public agencies are also accountable to the public and must comply with the numerous laws regulating public entities in California. Public Medi-Cal plans like CalOptima therefore need legal advice and services relating to a wide array of complex and specialized subject matter areas to meet the demands of an ever-changing healthcare and economic environment and operate in an effective and compliant manner.

Discussion

On September 2, 2021, during the regular Board of Directors (Board) meeting, the Board approved the Legal Ad Hoc's (Ad Hoc) recommendation to authorize the release of a Request for Proposals (RFP) for an outside law firm to serve as the agency's general counsel ("GC") to augment, and integrate with, the legal services currently provided by the agency's employed and contracted lawyers.

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As such, the RFP was released via BidSync on September 10, 2021, and the deadline to respond was October 11, 2021. CalOptima received a total of three proposals from the following firms:

- Kennaday Leavitt PC
- Nixon Peabody LLP
- Nossaman

As part of the review process the Ad Hoc, established on December 3, 2020, comprised of Chair Do, Vice Chair Corwin, and Director Becerra, reviewed all three proposals and subsequently conducted interviews with each firm on October 18, 2021. Each firm was evaluated based on the following weighted criteria:

- Experience – 35%
- Staffing – 35%
- Price – 30%

In addition, one of the office location qualifications under general requirements had been expanded from Southern California, to include all California regions.

The final weighted scoring for the RFP was as follows:

Vendor	Score
Kennaday Leavitt PC	4.70
Nossaman	4.35
Nixon Peabody LLP	3.00

Based on the review process and utilizing the aforementioned criteria, the Legal Ad Hoc recommends that CalOptima enter into a contract with Kennaday Leavitt PC to serve as the agency's general counsel for a term of November 4, 2021, to October 31, 2022, with two additional consecutive one-year extension options. The annual cost is estimated to be no more than $1.05 million, which includes basic services of approximately 2 full-time attorneys at $70,000 per month or $840,000 annually, and additional approved services and supports, including allowed business expenses, up to $210,000 a year. Funding will support continuity and efficiency in resolution of legal matters in a timely and effective manner.

The Ad Hoc strongly believes that Kennaday Leavitt has the knowledge and staff that will best organize and marshal the agency's legal resources to meet the substantial and increasing demand for legal services in conjunction with upcoming changes to Medi-Cal, such as California Advancing and Innovating Medi-Cal (CalAIM), addressing COVID-19, and the increasing demand for access to CalOptima services.

Fiscal Impact

The recommended action is unbudgeted. The estimated cost for Fiscal Year 2021-22 is approximately $700,000. The estimated annual cost is approximately $1.05 million. An allocation of up to $1.05 million from existing reserves will fund this action for the initial contract term of November 4, 2021, through October 31, 2022.

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Rationale for Recommendation

As part of the Board's strategic planning efforts, it is recommended that CalOptima retain Kennaday Leavitt PC to serve as the agency's outside GC to augment, and integrate with, the legal services currently provided by the agency's employed and contracted lawyers, and address the substantial and increasing demand for legal services.

Attachments

1. Entities Covered by this Recommended Action
2. Prior Board action dated September 2, 2021: Consider authorizing the preparation and release, subject to the Legal Ad Hoc's ("Ad Hoc") review, of Requests for Proposal ("RFP") for an outside law firm to serve as the agency's general counsel ("GC") to augment, and integrate with, the legal services currently provided by the agency's employed and contracted lawyers
3. Evaluator Scores
4. Kennaday Leavitt PC Offer Letter
5. Proposed CalOptima Contract with Kennaday Leavitt PC
    - Business Associates Agreement

/s/ Richard Sanchez — *10/28/2021*

Authorized Signature — **Date**

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Attachment to the November 4, 2021 Board of Directors Meeting – Agenda 8

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kennaday Leavitt PC	621 Capitol Mall, Suite 2500	Sacramento	CA	95814

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 2, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

17. Consider authorizing the preparation and release, subject to the Legal Ad Hoc's ("Ad Hoc") review, of Requests for Proposal ("RFP") for an outside law firm to serve as the agency's general counsel ("GC") to augment, and integrate with, the legal services currently provided by the agency's employed and contracted lawyers

Contact

Legal Ad Hoc Committee Members
Chair Andrew Do
Director Mary Giammona
Director Scott Schoeffel

Recommended Action(s)

Authorize the preparation and release, subject to the Ad Hoc's review, of an RFP for an outside law firm to serve as the agency's GC to augment, and integrate with, the legal services currently provided by the agency's employed and contracted lawyers.

Background

CalOptima is Orange County's ("County") public managed care health plan for County residents who are eligible for Medi-Cal benefits. As a county organized health care system, or "COHS," it is the sole health plan that eligible County residents may access to receive Medi-Cal program benefits. CalOptima currently arranges for the delivery of Medi-Cal health care services to over 800,000 beneficiaries, and it is anticipated that that number may grow significantly in the coming years. CalOptima also has a Medicare-Medi-Cal product, and a Program of All-Inclusive Care for the Elderly ("PACE") program, that both continue to grow in membership.

Managed care is a complex, expensive and challenging business. Managed care plans offering predominantly Medi-Cal programs, as well as dual-eligible and PACE programs, are even more complicated to operate because of substantial regulation by both the state and federal government. Managed Medi-Cal plans that are public agencies are also accountable to the public and must comply with the numerous laws regulating public entities in California. Public Medi-Cal plans like CalOptima therefore need legal advice and services relating to a wide array of complex and specialized subject matter areas to meet the demands of an ever-changing healthcare and economic environment and operate in an effective and compliant manner.

Discussion

The CalOptima Board of Directors ("Board") is undergoing a strategic planning endeavor. As part of this process the Ad Hoc, established on December 3, 2020 comprised of Chair Do, Director Giammona, and Director Schoeffel, has considered how best to organize and marshal the agency's legal resources to meet the substantial and increasing demand for legal services in conjunction with upcoming changes to Medi-Cal such as CalAIM, addressing COVID-19, and the increasing demand for access to CalOptima services.

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To that end, the Ad Hoc recommends that, through an RFP process, the Board explore the retention of an outside law firm to serve as the agency's GC to augment, and integrate with, the legal services currently provided by the agency's employed and contracted lawyers. Following the release of the RFP, the Ad Hoc will review applications and return to the Board with a future recommendation.

Upon Board approval, the attached scope of work will be included in the RFP and serve as the information that will be requested from each law firm who may be interested in applying for such a general counsel role as to its qualifications regarding the anticipated scope of work.

Fiscal Impact

The recommended action to authorize the preparation and release of an RFP, subject to the Ad Hoc's review, has no fiscal impact to CalOptima.

Rationale for Recommendation

As part of the Board's strategic planning efforts, exploring the retention of an outside law firm to serve as the agency's GC to augment, and integrate with, the legal services currently provided by the agency's employed and contracted lawyers, will address the substantial and increasing demand for legal services.

Attachments

General Counsel Proposed Scope of Work

_____ _____

Authorized Signature **Date**

Request for Proposal
CalOptima Outside General Counsel

Scope of Work

I. Introduction

CalOptima is Orange County's ("County") public managed care health plan for County residents who are eligible for Medi-Cal benefits. As a county organized health care system, or "COHS," it is the sole health plan that eligible County residents may access to receive Medi-Cal program benefits. CalOptima currently arranges for the delivery of Medi-Cal health care services to over 800,000 beneficiaries, and it is anticipated that that number may grow significantly in the coming years. CalOptima also has a Medicare-Medi-Cal product, and a Program of All-Inclusive Care for the Elderly (PACE) program, that both continue to grow in membership.

Managed care is a complex, expensive and challenging business. Managed care plans offering predominantly Medi-Cal programs, as well as dual-eligible and PACE programs, are even more complicated to operate because of substantial regulation by both the state and federal government. Managed Medi-Cal plans that are public agencies are also accountable to the public and must comply with the numerous laws regulating public entities in California ("Public Laws"). Public Medi-Cal plans like CalOptima therefore need legal advice and services relating to a wide array of complex and specialized subject matter areas to meet the demands of an ever-changing healthcare and economic environment and operate in an effective and compliant manner.

As part of its strategic planning efforts, the CalOptima Board of Directors ("Board") is considering how best to organize and marshal its legal resources to meet this substantial and increasing demand for legal services. To that end, the Board is exploring the retention of an outside law firm to serve as the agency's general counsel ("GC") to augment, and integrate with, the legal services currently provided by the agency's employed and contracted lawyers. The Board will be requesting information from each law firm who may be interested in applying for such a general counsel role as to its qualifications regarding the anticipated scope of work set forth below.

II. General Requirements.

A. The GC must have substantial experience in representing California managed care organizations ("MCO") that serve predominantly Medi-Cal populations. It must also be able to demonstrate experience representing MCOs serving dual-eligible and PACE program populations.

B. The GC must have an experienced senior lawyer who will serve as the principal and consistent point of contact with CalOptima personnel ("Principal Lawyer"). While it is anticipated that other GC lawyers may work on CalOptima matters from time to time, the Principal Lawyer will be the professional who regularly interacts with the Board, internal lawyers, and management personnel.

C. While it is anticipated that the GC may have multiple offices, the GC must maintain its principal offices in the Southern California area. The Principal Lawyer must be resident in one of the GC's Southern California offices.

III. Strategic Duties.

A. The GC will regularly provide the Board and management with reports on legal trends, issues, and best practices in California and across the healthcare industry, particularly in the public sector domain, that may materially affect CalOptima's business and mission, both currently and in the future.

B. The GC will regularly meet and confer with the Board and management to support CalOptima's strategic planning efforts as an integral member of CalOptima's senior management staff.

IV. Governance Duties.

A. The GC will report to the Board and shall attend all regular and special meetings of the Board, as well as other Board committee meetings by request.

B. The GC will work with internal lawyers to ensure compliance with all Public Laws related to CalOptima's governance.

B. The GC will work with internal lawyers to provide the Board with written summaries of all material legal issues concerning the agency on a regular basis, for monthly board meetings at a minimum.

V. Health Care and Privacy Oversight Duties.

A. The GC will work with CalOptima's compliance personnel and internal lawyers to establish and periodically update CalOptima's health care compliance programs and policies.

B. The GC will regularly attend CalOptima compliance committee meetings.

C. The GC will work with internal lawyers to engage, assist and manage outside compliance counsel and other consultants and support personnel as may be needed from time

to time, in connection with investigations, audits, responses to regulatory authorities, and other compliance matters that are not routine.

D. The GC will periodically report to the Board and management regarding any material compliance issues.

VI. Managed Care Regulatory Duties.

A. The GC will work with internal lawyers and outside counsel, where necessary, to ensure compliance with all regulatory requirements of the California Department of Health Care Services, the California Department of Managed Health Care, the federal Center for Medicare & Medicaid Services, and any other governmental entities with jurisdiction over the agency.

B. The GC will periodically report to the Board and management regarding any material regulatory issues.

VII. Managed Care Operations Duties.

A. The GC will work with internal lawyers to ensure that all legal issues related to CalOptima's managed care operations ("Operations Issues") are handled and resolved in a timely and appropriate manner. Operations Issues may involve a broad range of subject matter areas, including without limitation general business operations, payor and provider contracting, credentialing and administration, utilization review and quality assurance, member grievance resolution, provider dispute resolution, vendor contracting, procurement, real estate, intellectual property and technology, Public Laws, risk management and insurance, labor and employment, and general litigation.

B. The GC will work with internal lawyers to engage, assist and manage outside counsel and other consultants and support personnel as may be needed from time to time, to provide legal services in connection with Operations Issues.

C. The GC will periodically report to the Board and management regarding any material Operations Issues affecting the agency.

VIII. Management Duties.

A. The GC will be responsible for managing the overall legal affairs of the agency and coordinating the activities of the internal lawyers and outside legal counsel.

B. The GC will regularly advise the Board about the status of any material legal issues affecting the agency, and will be expected to keep the Board apprised of any legal issues that could adversely or positively affect CalOptima activities.

Evaluation Score Sheet					
RFP 22-018 - Outside General Counsel					
(Evaluation team members need only to fill in raw scores. The electronic score sheet will calculate the results for you.)					
Evaluator #1					
Company Name	Related experience and industry knowledge	Team and Staffing	Price	GRAND TOTAL	
	Everyone	Everyone	Everyone		
Kennaday Leavitt PC	(0 - 5)	(0 - 5)	(0 - 5)	(0 - 30)	
Score	5.00	5.00	4.00	14.00	
Weight	35%	35%	30%	100%	
total	1.7500	1.7500	1.2000	4.7000	**1.0000**
Nixon Peabody LLP	(0 - 5)	(0 - 5)	(0 - 5)	(0 - 30)	
Score	3.00	3.00	3.00	9.00	
weight	35%	35%	30%	100%	
total	1.0500	1.0500	0.9000	3.0000	**3.0000**
Nossaman	(0 - 5)	(0 - 5)	(0 - 5)	(0 - 30)	
Score	5.00	4.00	4.00	13.00	
weight	35%	35%	30%	100%	
total	1.7500	1.4000	1.2000	4.3500	**2.0000**

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RFP 22-018 - Outside General Counsel					
(Evaluation team members need only to fill in raw scores. The electronic score sheet will calculate the results for you.)					
Evaluator #2					
Company Name	Related experience and industry knowledge	Team and Staffing	Price	GRAND TOTAL	
	Everyone	Everyone	Everyone		
Kennaday Leavitt PC	(0 - 5)	(0 - 5)	(0 - 5)	(0 - 30)	
Score	5.00	5.00	5.00	15.00	
weight	35%	35%	30%	100%	
total	1.7500	1.7500	1.5000	5.0000	**1.0000**
Nixon Peabody LLP	(0 - 5)	(0 - 5)		(0 - 30)	
Score	3.00	3.00	2.00	8.00	
weight	35%	35%	30%	100%	
total	1.0500	1.0500	0.6000	2.7000	**3.0000**
Nossaman	(0 - 5)	(0 - 5)	(0 - 5)	(0 - 30)	
Score	5.00	5.00	4.00	14.00	
weight	35%	35%	30%	100%	
total	1.7500	1.7500	1.2000	4.7000	**2.0000**

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Evaluation Score Sheet					
RFP 22-018 - Outside General Counsel					
(Evaluation team members need only to fill in raw scores. The electronic score sheet will calculate the results for you.)					
Evaluator #3					
Company Name	Related experience and industry knowledge	Team and Staffing	Price	GRAND TOTAL	
	Everyone	Everyone	Everyone		
Kennaday Leavitt PC	(0 - 5)	(0 - 5)	(0 - 5)	(0 - 30)	
Score	4.50	4.50	4.50	13.50	
weight	35%	35%	30%	100%	
total	1.5750	1.5750	1.3500	4.5000	**1.0000**
Nixon Peabody LLP	(0 - 5)	(0 - 5)	(0 - 5)	(0 - 30)	
Score	4.00	3.00	3.00	10.00	
weight	35%	35%	30%	100%	
total	1.4000	1.0500	0.9000	3.3500	**3.0000**
Nossaman	(0 - 5)	(0 - 5)	(0 - 5)	(0 - 30)	
Score	4.50	4.50	4.00	13.00	
weight	35%	35%	30%	100%	
total	1.5750	1.5750	1.2000	4.3500	**2.0000**

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KENNADAY LEAVITT PC

November 5, 2021

James F. Novello
916-732-3062 (Direct)
jnovello@kennadayleavitt.com

VIA E-MAIL

Richard Sanchez
CEO CalOptima

Re: Engagement for Legal Services

Dear Mr. Sanchez:

Thank you for retaining Kennaday Leavitt PC ("KL," "we," or "us") to assist CalOptima with its legal matters specified below. All terms contained in the Contract and Scope of Work titled, "CONTRACT NO. XX-XXXXX BETWEEN ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba CALOPTIMA, hereinafter "the CalOptima Agreement" are incorporated by reference into this Engagement Agreement. In the event of any conflict in terms, the CalOptima Agreement shall supersede the terms in this Engagement Agreement, unless such terms are required by the California State Bar through its jurisdiction over Attorneys and Professional Legal Corporations. Our firm looks forward to working with you.

1. General Nature of Legal Services. You have retained us to provide Outside General Counsel Services as stated in the CalOptima Agreement and Scope of Work.

2. Responsibilities of Attorneys. We agree to provide such legal services as we determine are reasonably required to represent and advise you in connection with the engagements specified in Paragraph 1 above. We will take reasonable steps to keep you informed of the progress of this matter, and will respond in a reasonably prompt manner to your inquiries. The scope of this engagement is limited to the services described in Paragraph 1. Legal services not covered by this Engagement letter will usually not be performed without your request or authorization. However, we may provide legal services for additional matters which you request from time to time, so long as we consent to the engagement.

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3. Responsibilities of Client. You agree to be completely truthful with us, to cooperate and keep us fully informed of developments, to abide by this Agreement and to promptly pay our bills for services and costs in accordance with the provisions in this Agreement, including the provisions pertaining to Compensation, Costs and Expenses, and Billing and Payment Responsibilities. You agree to preserve any and all information and evidence that may be relevant to this matter or potential litigation in this matter. You agree to preserve the originals of all exhibits and other evidence and to provide us only with electronically scanned duplicates or photocopies of exhibits. You agree to preserve all hard-drives, email storage accounts and other electronic records associated you're your business practices related to the matters on which we are engaged. Scheduled routine destruction of any stored records that are relevant to this matter, whether in hard copy or electronic format, must be immediately temporarily suspended until after this matter is concluded. You agree that you are responsible for determining if any insurance is available for the matters described in Paragraph 1 and for providing timely notice of the matters to any agent, broker and/or insurer.

4. Basis of Compensation. As compensation for our services, you agree to pay us based on the fees outlined in Contract 22-10289, Exhibit B.

Although the persons identified in our contract section 2.2 will primarily be responsible for advising and representing you, other attorneys and non-attorney personnel in our office may also work on your matter. If other personnel are asked to perform services, you will be informed of their billing rates on the statement following their initial service. Such delegation may be for the purpose of involving lawyers or legal assistants with special expertise or for the purpose of providing services on the most efficient and timely fashion. However, we anticipate that the attorneys listed above will render the bulk of the legal services to you. By this Agreement you retain the legal services of KL and not of a particular attorney.

We cannot predict in advance the total amount of legal fees that will be required for this Engagement. While we make a good faith effort to estimate potential fees, you understand that all estimates are based on limited factual information, assumptions, and variables that may change during the course of this matter. We cannot guarantee or make any representation as to the total fees and/or costs of the services described in Paragraph 1 because it is currently unknown how much time and effort will be required to adequately represent your interests in this matter. You understand that the estimates are not precise and actual fees may vary significantly from any estimate provided.

5. Costs and Expenses. We will ordinarily incur various costs and expenses on behalf of our clients, or provide certain in-house services while performing legal services. The costs and expenses and in-house services may include, but will not necessarily be limited to, filing fees required by courts or other agencies; court reporter fees; transcript fees;

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witness fees; expert fees; consultant fees; process server fees; investigation expenses; messenger and private courier delivery charges; in-house photocopying at $0.20 per page and other reproduction services; and other similar items. You agree that large expenditures shall be routed to you for direct payment.

We will not charge you for word processing, overtime expenses associated with administrative or secretarial personnel, telephone calls within the United States and similar items unless these items are unusually large in amount and we obtain your agreement in advance.

6. Billing and Payment Responsibilities. In accordance with Exhibit B of Contract 22-10289, we will send you a monthly statement or invoice ("Statement") for our time, describing the services performed and the amount of the fees and costs payable by you. Payment is due within 30 days of the date of the Statement. If not paid within 30 days, interest shall accrue at the rate of five percent per annum from the due date on the Statement. We will provide notice if your account becomes delinquent. You agree to bring your account current within 15 days upon notice of delinquency. If you have questions or concerns regarding the charges, call us immediately to discuss and resolve the matter. It is important that we resolve your concerns promptly so that we may better serve you.

7. No Guarantee. No representations or guarantee with regard to the outcome of our efforts on your behalf have been made. We do not and cannot warrant or guarantee that we will be successful in prosecuting or defending any litigation on your behalf or in any other legal matter. Any expressions on our part concerning the outcome of your legal matters are expressions of our best professional judgment, but are not guarantees.

8. Client Identity and Conflict Check. You agree that CalOptima is our client for the specific matters set forth in Paragraph 1. We shall not be deemed to represent any other corporate parents, subsidiaries, or other affiliates unless we expressly agree to do so in writing. Our representation of a corporation, partnership, joint venture, association, or other entity does not include a representation of the individuals or entities that are shareholders, officers, directors, partners, joint ventures, employees, or members of such entities or their interests in such entities. Any proposed expansion of the representation to include any such related persons or entities shall be subject to and contingent upon execution of an engagement letter directly with those persons or entities. We performed our conflict check based upon information provided to us. We are not bound to avoid conflicts with other entities that you have not identified to us. Should CalOptima's Board of Directors change, and should such change include someone that KL has a conflict with, KL will notify CalOptima immediately.

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9. Contact Information. You agree to keep us informed of any change in your address, telephone numbers, or electronic mail address so that we may effectively communicate with you. We will also advise you promptly of any change with KL's business address, electronic mail address or telephone or facsimile numbers.

10. Termination of Services. You may discharge our services at any time by written notice according to the terms of the CalOptima Agreement. After receiving such notice, and after obtaining the Court's permission, if necessary, we will cease providing services to you under this Agreement. You agree to cooperate with us in facilitating the orderly transfer of your case to new counsel, including promptly signing a substitution of counsel form at our request.

We may withdraw as your attorneys with your consent or for other reasons as permitted or required by law. The types of conduct or circumstances that require or allow us to withdraw from representing a client include, among other things, a client's failure to pay our statement within 30 days of its due date, failure to comply with the terms in this Agreement, including the duty to cooperate, a client's misrepresentation or failure to disclose material facts to us or refusal to follow our advice on a material matter, the development of irreconcilable disagreement as to the conduct or nature of our Engagement, or any other circumstances that either mandates or permits termination of this engagement under the rules of our profession. Our failure to withdraw as your attorneys on any one occasion shall not be a waiver of our right to do so if such other occasions arise. Termination of our services will not relieve you of your obligation to pay for services rendered and for costs incurred prior to the cessation of our services.

11. Client File. We will retain your file, either in hard copy or electronic form, at our election, for a period of ten (10) years, after which time we may have your file destroyed. If you desire to have your file maintained beyond ten years after the conclusion of this Engagement, a separate arrangement with us is required as we may destroy the file after the passage of such time with or without specific consent from you particularly if we cannot contact you. If you request a copy of your client file, we reserve the right to copy your entire client file. You agree to reimburse us for any and all copying costs incurred as a result of copying your client file.

12. Lien. By signing below, you agree that in the event you become delinquent according to the Compensation and Payment Terms contained in the CalOptima Agreement, we may file a lien for unpaid attorney fees and costs on any claim that is the subject of this Engagement regardless of whether or not we are representing you at the time of recovery. You have the right to seek the advice of a counsel of your choice regarding this lien. By signing below, you agree that you have been provided a reasonable opportunity to seek the advice of independent counsel regarding this provision.

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13. Effective Date. This Agreement will take effect as of the date the Engagement letter, Contract 22-10289, and the Business Associate Agreement are last signed.

14. Miscellaneous Matters. This Agreement is made under and shall be construed in accordance with the substantive laws of the State of California without reference to its choice of law rules. In addition, any dispute which may arise from this Agreement shall be resolved in Orange County, California.

15. Entire Agreement. This Engagement letter, Contract 22-10289, and the Business Associates Agreement constitutes a single, integrated written contract expressing the entire agreement between you and KL concerning the legal services you have engaged us to provide. There is no other agreement, written or oral, express or implied, between us with respect to this Engagement. This Agreement replaces any prior understandings or arrangements. Any modifications or additions to this Agreement must be agreed to in writing by us. This Agreement shall be construed by giving effect to the plain meaning of its terms.

If the terms of this Agreement are satisfactory, please sign in the space provided below and return the signed original to me.

Again, thank you for allowing us the opportunity to work with you on this matter.

Very truly yours,

JAMES F. NOVELLO

ACCEPTANCE

I have read and understand the foregoing terms and agree to them as of the date KL first provided services to CalOptima.

Date: _____ By: _____
Nancy Huang
CalOptima, Chief Financial Officer

Date: _____ By: _____
Richard Sanchez
CalOptima, Chief Executive Officer

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CONTRACT NO. 22-10289
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA
And
KENNADAY LEAVITT PC
(CONTRACTOR)

THIS CONTRACT ("Contract") is made and entered into as of the date last signed below, by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima" and Kennaday Leavitt PC, hereinafter referred to as "CONTRACTOR." CalOptima and CONTRACTOR shall be referred to herein collectively as the "Parties" or individually as a "Party."

RECITALS

A. CalOptima desires to retain a CONTRACTOR to provide Outside General Counsel Services, as described in the Scope of Work; and

B. CONTRACTOR provides such services; and

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

D. CONTRACTOR desires to perform these services for CalOptima; and

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

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. This Contract shall include the following documents ("Contract Documents"), in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and attachments, and any amendments thereto; (ii) CalOptima's Request for Proposal ("RFP"), 22-018, inclusive of any revisions, amendments and addenda thereto, and; (iii) CONTRACTOR's proposal dated October 01, 2021. Any new terms and conditions attached to CONTRACTOR's best and final offer, proposal, invoices, or request for payment, shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All documents attached to this Contract and/or referenced herein as a "Contract Document" are incorporated into this Contract by this reference, with the same force and effect as if set forth herein in their entirety. Changes hereto shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima and issued in accordance with Section 17, Modifications, herein. In the event of any conflict of provisions among the documents constituting the Contract, the provisions shall prevail in the above-referenced descending order of precedence.

2. Statement of Work.

2.1 CONTRACTOR shall perform the work necessary to complete, in a manner satisfactory to CalOptima, and if applicable, to the Centers for Medicare and Medicaid Services ("CMS"), the California Department of Health Care Services ("DHCS"), and/or the California Department of Managed Health Care ("DMHC"), as applicable, the services set forth in Exhibit A entitled "Scope of Work," which is attached hereto and incorporated herein by this reference. CONTRACTOR shall also perform in accordance with its Proposal dated October 01, 2021.

2.2 CONTRACTOR shall provide the personnel listed below to perform the above-specified services, which persons are hereby designated as key personnel under this Contract. No person named in this Section 2, or his/her successor approved by CalOptima, shall be removed or replaced by CONTRACTOR, nor shall his/her agreed-upon function or level of commitment hereunder be changed without the prior written consent of CalOptima.

Name	Function/Title
Jim Novello	Principal Lawyer
Curtis Leavitt	Primary Risk Assessor
Troy Szabo	Primary Regulatory and Compliance Lead
Kelli Kennaday	Primary Employment Law Contact

3. Insurance.

3.1 Prior to undertaking performance of services under this Contract and at all times during performance hereunder, and entirely at CONTRACTOR's sole expense, CONTRACTOR shall maintain the following insurance, which shall be full-coverage insurance not subject to self-insurance provisions, and CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the term of this Contract:

3.1.1 Required Insurance:

3.1.1.1 Commercial General Liability, including Contractual liability and coverage for Independent Contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

3.1.1.2 Per Occurrence: $1,000,000

3.1.1.3 Personal Advertising Injury: $1,000,000

3.1.1.4 Products Completed Operations: $2,000,000

3.1.1.5 General Aggregate: $2,000,000

3.1.2 Commercial Automobile Liability covering any auto, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

3.1.3 Workers' Compensation and Employers' Liability Policy written in accordance with the laws of the State of California and providing coverage for all of CONTRACTOR's employees:

3.1.3.1 This policy must provide statutory coverage for Workers' Compensation.

3.1.3.2 This policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

3.1.4 Professional Liability insurance covering the CONTRACTOR's professional errors and omissions with the following minimum limits of insurance:

3.1.4.1 Per occurrence: $1,000,000

3.1.4.2 General aggregate: $2,000,000

3.1.5 Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and theft of client property, with the following minimum limits of $1,000,000 per occurrence:

3.1.5.1 Cyber and Privacy Liability insurance with the following minimum limits of insurance covering claims involving privacy violations, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security. Such coverage is required only if any products and/or services related to information technology (including hardware and/or software) are provided to Insured and for claims involving any professional services for which CONTRACTOR is engaged with Insured for such length of time as necessary to cover any and all claims.

a) Privacy and Network Liability: $1,000,000

b) Internet Media Liability: $1,000,000

c) Business Interruption & Expense: $1,000,000

d) Data Extortion: $1,000,000

e) Regulatory Proceeding: $1,000,000

f) Data Breach Notification & Credit Monitoring: $1,000,000

3.2 Prior to commencement of any work hereunder, CONTRACTOR shall furnish to CalOptima's Purchasing Department additional insured endorsements and also broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR, and further providing that:

Certificate Requirements:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this contract, the CONTRACTOR's insurance coverage shall be primary insurance as respects to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies.

3.2.3 The Insurance Company agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the CONTRACTOR for CalOptima. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this clause. All certificates and endorsements are to be received and approved by CalOptima before work commences. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If CONTRACTOR maintains higher limits than the minimums required above, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

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

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

3.4 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

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

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR agrees to and shall save, defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "Indemnified Parties") from and against any liability whatsoever, based or asserted upon any services of the CONTRACTOR, its officers, employees, subcontractors, agents, or representatives (individually and collectively referred to as "Indemnitors") arising out of or in any way relating to this Contract, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever arising from the performance of Indemnitors under this Contract. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions, at its sole expense, which shall include all costs and fees, including, but not limited to, attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding.

4.2 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder. The terms of this Contract are contractual and the result of negotiation between the Parties hereto. Accordingly, any rule of construction of contracts (including, without limitation, California Civil Code Section 1654) that ambiguities are to be construed against the drafting party, shall not be employed in the interpretation of this Contract.

4.3 CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except Claims arising through the sole negligence or sole willful misconduct of CalOptima.

4.4 It is expressly understood and agreed that the foregoing provisions are intended to be as broad and inclusive as permitted by the law of the State of California and that CONTRACTOR's indemnification and duty to defend obligation hereunder shall survive the expiration or earlier termination of this Contract until such time as action against the Indemnified Parties for such matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including but not limited to those set forth under the California Government Claims Act (Cal. Gov. Code §900 et seq.).

4.5 It is not the intent of the Parties that the provisions of this Section and the Indemnification provision(s) set forth in the Business Associate Protected Health Information Disclosure Agreement executed by the Parties shall be in conflict. In the event of any conflict, the Indemnification provision(s) in the Business Associate Protected Health Information Disclosure Agreement shall be interpreted to relate only to matters within the scope of that Agreement.

4.6 The terms of this Section shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which term shall include any and all subcontractors, and any agents or employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control, and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees in connection with this Contract, and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters. At CONTRACTOR's expense as described herein, CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of CONTRACTOR's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "Employment Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

6. Assignments; Subcontracts.

6.1 Except as specifically permitted hereunder, CONTRACTOR may not assign, transfer, delegate or subcontract any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion. In the event CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, delegation, or subcontract may additionally be subject to the prior

written approval of DHCS. Any assignment, transfer, delegation, or subcontract made without CalOptima's express written consent shall be deemed void.

6.2 For purposes of this Section and this Contract, assignment is: (1) the change of more than twenty-five percent (25%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than twenty-five percent (25%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g. the Board of Directors) to a third-party management person, company, group, team or other entity.

6.3 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Non-Exclusive Relationship. It is understood by the parties that this is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

8. Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima Policies relating to services under the Contract that are in effect when this Contract is signed or which may come into effect during the term of this Contract.

9. Nondiscrimination Clause Compliance.

9.1 During the performance of this Contract, CONTRACTOR and its subcontractor(s) shall not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, medical condition (including cancer), age (over 40), marital status, and the use of family and medical care leave and pregnancy disability leave. CONTRACTOR and subcontractor(s) shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. CONTRACTOR and subcontractor(s) shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq. and the applicable regulations promulgated thereunder Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in Chapter 5 of Division 4, Title 2, CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. CONTRACTOR and its subcontractor(s) shall give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. CONTRACTOR shall also fully comply with the following, to the extent applicable to the services provided by CONTRACTOR under this Contract: Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as California Government Code Section 11135 (ethnic group identification,

religion, age, sex, color, physical or mental handicap); California Civil Code Section 51 (all types of arbitrary discrimination); and all rules and regulations promulgated pursuant thereto.

9.2 CONTRACTOR shall include the nondiscrimination and compliance provisions of Section 9 in all subcontracts under this Contract.

10. Prohibited Interest.

10.1 CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict of interest laws, including but not limited to CalOptima's Conflict of Interest Code, the California Political Reform Act (Government Code Section 81000 et seq.) and Government Code Section 1090 et seq. (collectively, the "Conflict of Interest Laws").

10.2 CONTRACTOR covenants that, for the term of the Contract, no director, officer, or employee of CalOptima during his tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the term of this Contract, and consistent with the provisions of Title 22 California Code of Regulations (CCR) Section 53600(f), no state officer or state employee shall be employed in a management or contractor position by CONTRACTOR within one year after the state office or state employee has terminated state employment.

10.3 No employee, officer or agent of CalOptima shall participate in the selection, award or administration of an agreement, or in any decision that may have foreseeable impact on CONTRACTOR if a conflict of interest, real or implied, exists. Such a conflict arises when any of the following has a financial or other interest in the firm selected for award:

10.3.1 A CalOptima employee, officer or agent;

10.3.2 Any member of the employee, officer or agent's immediate family;

10.3.3 The employee, officer or agent's domestic or business partner; and

10.3.4 An organization that employs or is about to employ any of the above.

10.4 CONTRACTOR, 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.

10.5 CONTRACTOR understands that, if this Contract is made in violation of Government Code Section 1090 et seq., the entire Contract is voidable and CONTRACTOR will not be entitled to any compensation for Services performed pursuant to this Contract and CONTRACTOR will be required to reimburse CalOptima any sums paid to CONTRACTOR. CONTRACTOR further understands that, in addition to the foregoing, CONTRACTOR may be subject to criminal prosecution for a violation of Government Code Section 1090.

10.6 If CONTRACTOR hereinafter becomes aware of any facts, which might reasonably be expected to either create a conflict of interest under the Conflict of Interest laws or violate the provisions of this Section, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include, without limitation, identification of all persons, entities and businesses implicated and a complete description of all relevant circumstances.

11. Disclosure of Officers, Owners, Stockholders and Creditors. On an annual basis and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit I, attached hereto and incorporated by this reference:

11.1 All officers and owners who own greater than 5% of the CONTRACTOR; and

11.2 All stockholders owning greater than 5% of any stock issued by CONTRACTOR.

11.3 All creditors of CONTRACTOR's business if such interest is over 5%.

12. Equal Opportunity.

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

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

12.3 CONTRACTOR and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of CONTRACTOR and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

12.4 CONTRACTOR and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

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

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

12.7 CONTRACTOR and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or CONTRACTOR. CONTRACTOR and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event CONTRACTOR and its Subcontractors become involved in, or are threatened with litigation by a subcontractor or CONTRACTOR as a result of such direction by DHCS, CONTRACTOR and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

13. Standard of Performance; Warranties.

13.1 CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

13.2 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work.

13.3 CONTRACTOR expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including, without limitation, CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. CONTRACTOR further warrants that all material covered by this Contract, if any, which is the product of CONTRACTOR will be new and unused unless otherwise

specified, and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to CONTRACTOR, CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage to other parts of the system resulting from such defects. CalOptima shall give notice to CONTRACTOR of any observed defects. In the event that CONTRACTOR fails to make adjustments, repairs, corrections, or other work made necessary by such defects, CalOptima may do so and charge CONTRACTOR the costs incurred.

13.4 CONTRACTOR's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

13.5 CONTRACTOR's obligations under this Section are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both parties.

13.6 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair and replacement by CONTRACTOR at no cost to CalOptima.

14. Compensation.

14.1 Payment.

14.1.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full consideration for the faithful performance of this Contract, the rates, charges and other payment terms identified in Exhibit B, which is attached hereto and incorporated herein by this reference.

14.1.2 CalOptima will not reimburse CONTRACTOR any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

14.1.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance as set forth in the Contract and Exhibit A, Scope of Work that may be reasonably expected by CalOptima. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING UNDER THIS CONTRACT.**

14.1.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in the attached Exhibit B, without the express prior written authorization of CalOptima. CONTRACTOR shall at all times monitor its costs and expenditures for work performed under this Contract, and shall monitor its invoices, costs, and expenditures, to ensure it does not exceed the maximum cumulative payment obligation set forth herein. CONTRACTOR shall provide CalOptima with 60 days written notice if at any time during this Contract CONTRACTOR becomes aware that it may exceed the maximum cumulative payment obligation authorized under this Contract. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA**

SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.

14.1.5 The maximum cumulative payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. CONTRACTOR is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise to be paid by CalOptima to CONTRACTOR due to CONTRACTOR'S failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed and pay them to the appropriate taxing authority, and shall have no liability for or any obligation to refund any payments withheld.

14.2 Contractor Travel Policy. CONTRACTOR agrees to abide by the terms of the CalOptima Travel Policy, attached hereto as Exhibit C, and incorporated herein by this reference.

15. Term. This Contract shall commence on the date last signed below, and shall continue in full force and effect through October 31, 2022, ("Initial Term"), unless earlier terminated as provided in this Contract. At the end of the Initial Term, CalOptima may, at its option, extend this Contract for up to Two (2) additional consecutive one (1) year terms ("Extended Terms"), provided that if CalOptima does not exercise its option to extend at the end of the Initial Term, or any Extended Term, the remaining option(s) shall automatically lapse. As used in this Contract, the word "Term" shall include the Initial Term and any and all Extended Term(s), to the extent CalOptima exercises its option pursuant to this paragraph.

16. Termination.

16.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days written notice hereof. Upon termination, CalOptima may pay CONTRACTOR its allowable cost incurred for services satisfactorily performed and accepted by CalOptima as of the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

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

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

16.2.2 In the event of Termination for Unavailability of Funds, as provided in this Section, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items, including, without limitation, lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

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

16.3 Termination for Default. Subject to a ten (10) day cure period, CalOptima may terminate this Contract for CONTRACTOR's default, or if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR, or if CONTRACTOR makes an assignment for the benefit of creditors as defined in Section 6, or if CONTRACTOR breaches any term(s) or violates any provision(s) of this Contract and does not cure such breach or violation within ten (10) days after written notice thereof by CalOptima. In the event of Termination for Default, as provided by this Section, CONTRACTOR shall be liable for any and all reasonable costs incurred by CalOptima as a result of such default, including, but not limited to, reprocurement costs of the same or similar services defaulted by CONTRACTOR under this Contract.

16.4 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3, (Insurance), Section 10, (Prohibited Interest), or Section 24, (Confidentiality).

16.5 Effect of Termination. Upon expiration or receipt of a termination notice under this Section:

16.5.1 CONTRACTOR shall promptly discontinue all services (unless the notice directs otherwise), and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs and any other products, data and such other materials, equipment, and information, including but not limited to confidential information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure. Failure to return any information or equipment, badge or access card, is considered a material breach of this Contract and CalOptima's privacy and security rules.

16.5.2 CalOptima may take over the services, and may award another party a contract to complete the services under this Contract.

16.5.3 CalOptima may withhold from payment any sum that it determines to be owed to CalOptima by CONTRACTOR, or as necessary to protect CalOptima against loss due to outstanding liens or claims of former lien holders.

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

18. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, or the California Department of Health Care Services, or the California Department of Managed Health Care, or the Department of Justice, or the Bureau of Medical Fraud, copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement between a subcontractor and an organization related to the subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees

and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

19. Confidential Material.

19.1 During the term of this Contract, either Party may have access to confidential material or information ("Confidential Information") belonging to the other Party or the other Party's customers, vendors, or partners. "Confidential Information" shall include without limitation the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements and licensing plans or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

19.2 For the purposes of this Section 19, "Confidential Information" does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other's Confidential Information or proprietary information; (iv) is received from a third party which is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure pursuant to California Public Records Act, Government Code Section 6250 et seq., applicable provisions of California Welfare and Institutions Code or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

19.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers or agents on a "need to know" basis in connection with the services performed under this Contract, who are bound by confidentiality obligations no less stringent than these prior to any disclosure. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; providing that the receiving Party shall give reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and shall assist the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or Court does not relieve the receiving Party of its confidentiality obligations with respect to any other party.

19.4 Except as to the confidentiality of trade secrets, these confidentiality restrictions and obligations will terminate five (5) years after the expiration or termination of the Contract, unless the law requires a longer period. Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party all documents, notes and other tangible materials representing the disclosing Party's Confidential Information or Proprietary Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

19.5 For the purposes of this Section only, "Confidential Information" does not include protected health information or individually identifiable information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other privacy statutes or regulations. The access, use and disclosure of Protected Health Information is referenced below in Section 24, and shall be governed by a Business Associate Protected Health Information Disclosure Agreement, which shall be executed by the parties if CONTRACTOR will create, receive, maintain, use, or transmit Protected Health Information in performing services under this Contract.

20. Record Ownership and Retention.

20.1 The originals of all letters, documents, reports, software programs and any other products and data prepared or generated for the purposes of this Contract shall be delivered to, and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records, but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

20.2 CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("Works"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including, but not limited to, documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

20.3 Notwithstanding the foregoing, CONTRACTOR's intellectual property ("CONTRACTOR IP") that preexists this Contract shall remain the sole and exclusive property of CONTRACTOR. CONTRACTOR shall not incorporate any CONTRACTOR IP into the Works that would limit CalOptima's use of the Works without CalOptima's written approval. To the extent that CONTRACTOR incorporates any CONTRACTOR IP into the Works, CONTRACTOR hereby grants to CalOptima a non-exclusive, irrevocable, perpetual, worldwide, royalty-free license to use and reproduce the CONTRACTOR IP to the extent required to fully utilize the Works.

20.4 CONTRACTOR acknowledges and agrees that, notwithstanding any provision herein to the contrary, CalOptima's Intellectual Property ("CalOptima IP") in the information, documents and other materials provided to CONTRACTOR shall remain the sole and exclusive property of CalOptima. Any information, documents or materials provided by CalOptima to CONTRACTOR pursuant to this Contract and all copies thereof (including without limitation CalOptima IP, Proprietary Information and Confidential Information, as these terms are defined in Section 19) shall upon the earlier of CalOptima's request or the expiration or termination of this Contract be returned to CalOptima.

20.5 For purposes of this Section, Intellectual Property shall mean patents, copyrights, trademarks, trade secrets, and other proprietary information.

21. Patent and Copyright Infringement. In lieu of any other warranty by CalOptima or CONTRACTOR against infringement, statutory or otherwise, it is agreed that CONTRACTOR shall indemnify, hold harmless and defend, at its expense, any suit against CalOptima based on a claim that any item furnished under this Contract, or the normal use or sale thereof, infringes on any United States letters patent, patent, trademark, copyright, or other intellectual property right, and shall pay costs and damages finally awarded in any such suit, provided that CONTRACTOR is notified in writing of the suit and given authority, information, and assistance at CONTRACTOR's expense for the defense of the suit. CONTRACTOR, at no expense to CalOptima, shall obtain for CalOptima the right to use and sell said item, or shall substitute an equivalent item acceptable to CalOptima and extend this patent indemnity thereto.

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

23. Business Associate Protected Health Information Disclosure Agreement. CONTRACTOR agrees to and shall enter into a Business Associate Protected Health Information Disclosure Agreement with CalOptima, with a Security Requirements Attachment for DHCS Data and Protected Health Information/Personal Information (PHI/PI) if CONTRACTOR will create, receive, maintain, use, or transmit DHCS data or PHI/PHI, which agreement shall be incorporated herein by this reference. CONTRACTOR acknowledges and agrees that CalOptima reserves the right to modify the Business Associate Protected Health Information Disclosure Agreement at any time should such modification be required by applicable law or regulation.

24. Confidentiality of Member Information.

24.1 CONTRACTOR and its employees, agents, or subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

24.2 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by CONTRACTOR or its Subcontractors, CONTRACTOR:

24.2.1 Will not use any such information for any purpose other than carrying out the express terms of this Contract;

24.2.2 Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law;

24.2.3 Will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under; and

24.2.4 Will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose.

24.3 CONTRACTOR agrees to complete a CalOptima Medi-Cal Data Access Agreement, which is attached hereto as Exhibit D and incorporated herein by this reference. All materials covered under this Medi-Cal Data Access Agreement shall be designated confidential, to the extent permitted by California law.

25. Offshore Performance.

25.1 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.

25.2 CONTRACTOR shall complete, sign, and return Exhibit H, entitled "Attestation Concerning the Use of Offshore Subcontractors," which is attached hereto and incorporated herein by this reference, and shall submit an executed Offshore Subcontractor Attestation no less than annually thereafter.

25.3 CONTRACTOR acknowledges that CalOptima requires CONTRACTOR to obtain approval from it of CONTRACTOR's use of any offshore subcontractor whereby offshore subcontractor will have access to any type of confidential CalOptima Member information, including, but not limited to, protected health information. CONTRACTOR represents and warrants that it has disclosed to CalOptima any and all such offshore subcontractors within Exhibit H and that it has obtained CalOptima's written approval to use such offshore subcontractors prior to the effective date of this Contract.

25.4 Any new 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's Purchasing Department 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.

25.5 Unless specifically stated otherwise in this Contract, the restrictions of this Section do not apply to indirect or "overhead" services, or services that are incidental to the performance of the Contract.

25.6 The provisions of this Section apply to work performed by subcontractors at all tiers.

26. Medicare Advantage Program. CONTRACTOR agrees to abide by the terms of "Addendum 1, Medicare Advantage Program," attached hereto as Exhibit G and incorporated herein by this reference.

27. Time is of the Essence. Time is of the essence in performance of this Contract.

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

29. Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, the party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments, as may be necessary to perform the objectives of this Contract.

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

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

32. Notices. All notices required or permitted under this Contract and all communications regarding the interpretation of the terms of this Contract, or changes thereto, shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any party whose address changes shall notify the other party in writing.

To CONTRACTOR:	To CalOptima:
Kennaday Leavitt PC	CalOptima
621 Capitol Mall, Suite 2500	505 City Parkway West
Sacramento, CA 95814	Orange, CA 92868
Attention: Jim Novello	Attention: Ryan Prest

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

34. Unavoidable Delays.

34.1 If the delivery of services under this Contract should be unavoidably delayed, CalOptima's Purchasing Department shall extend the time for completion of the Contract for the determined number of days of excusable delay. A delay is unavoidable only if the delay was not reasonably expected to occur in connection with, or during CONTRACTOR's performance, and was not caused directly or substantially by acts, omissions, negligence, or mistakes of CONTRACTOR, CONTRACTOR's subcontractors, or their agents, and was substantial and in fact caused CONTRACTOR to miss delivery dates, and could not adequately have been guarded against by contractual or legal means. Delays caused by CalOptima will be sufficient justification for delay of services, and CONTRACTOR shall be allowed a day-for-day extension.

34.2 CONTRACTOR shall notify CalOptima's Purchasing Department as soon as CONTRACTOR has, or should have, knowledge that an event has occurred that will delay deliveries. Within five (5) working days, CONTRACTOR shall confirm such notice in writing, furnishing as much detail as is available.

34.3 CONTRACTOR agrees to supply, as soon as such data is available, any reasonable proof that is required by CalOptima's Purchasing Department to make a decision on any request for extension. CalOptima's Purchasing Department shall examine the request and any documents supplied by

CONTRACTOR and shall determine if CONTRACTOR is entitled to an extension and the duration of such extension. CalOptima's Purchasing Department shall notify CONTRACTOR of this decision in writing. It is expressly understood and agreed that CONTRACTOR shall not be entitled to damages or compensation, and shall not be reimbursed for losses on account of delays resulting from any cause under this provision.

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

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

37. Entire Agreement. This Contract, including all exhibits and documents incorporated by reference and all Contract Documents referenced in Section 1 herein, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

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

39. Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power, or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof, or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

40. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 et seq.) (the "Public Records Act"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless they are exempt from disclosure under the provisions of the Public Records Act. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the Public Records Act. In the event that CONTRACTOR discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the Public Records Act that are not so marked. In the event CalOptima receives a request under the Public Records Act that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees, and any costs awarded to the

person or entity that sought the CONTRACTOR marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR marked material (collectively referred to for purposes of this Section as "Public Records Act Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

41. Audit Disclosure. Pursuant to California Government Code Section 8546.7, if this Contract is over ten thousand dollars ($10,000), it is subject to examination and audit of the State Auditor, at the request of CalOptima, or as part of any audit of CalOptima, for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract or its attachments, CONTRACTOR agrees that, during the term of this Contract and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period.

42. Debarment and Suspension Certification.

42.1 By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable Federal suspension and debarment regulations.

42.2 By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

42.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

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

42.2.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph 42.2.2 herein;

42.2.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

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

42.2.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

42.3 If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima.

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

42.5 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.

43. Lobbying Restrictions and Disclosure Certification.

43.1 Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.

43.2 Certification and Disclosure Requirements.

43.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Exhibit E, Part 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 43.3of this provision. Exhibit E is attached hereto and incorporated herein by this reference.

43.2.2 Each recipient shall file a disclosure (in the form set forth in Exhibit E, Part 2, entitled "Certification Regarding Lobbying") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 43.3 of this provision if paid for with appropriated funds.

43.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 43.2.2herein. An event that materially affects the accuracy of the information reported includes:

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

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

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

43.2.3.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 43.2.1of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

43.2.3.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 43.2.1of this provision. That person shall forward all disclosure forms to CalOptima Purchasing Manager.

43.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions, the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative

agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

44. Air and Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR § 15.5. CONTRACTOR agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 et seq.), as amended.

45. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Prohibited Interest, Warranties, Compensation, Confidentiality, Indemnification, Duty to Defend, Ownership of Records and Documents, Record Retention, Audit Disclosure, California Public Records Act, Patent and Copyright Infringement, Governing Law, and this Section.

46. Severability. If any section, subsection or provision of this Contract, or any Contract Documents incorporated into this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall not be affected thereby.

47. 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.

48. Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties to this Contract. Nothing in this Contract is intended to confer upon any Party other than the Parties hereto or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

49. 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.

50. Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

[Remainder of page left intentionally blank. Signatures on following page]

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. 22-10289 on the day and year last shown below.

Kennaday Leavitt PC	CalOptima
By: Curtis Leavitt	By:
Print Name: CURTIS LEAVITT	Print Name:
Title: SECRETARY	Title:
Date: 10-27-21	Date:
By:	By:
Print Name: Kelli Kennaday	Print Name:
Title:	Title:
Date: 10/27/21	Date:

If CONTRACTOR is a corporation, two officer signatures or a Corporation Resolution or Corporate Seal is required

Exhibit A

SCOPE OF WORK

I. Introduction

CalOptima is Orange County's ("County") public managed care health plan for County residents who are eligible for Medi-Cal benefits. As a county organized health care system, or "COHS," it is the sole health plan that eligible County residents may access to receive Medi-Cal program benefits. CalOptima currently arranges for the delivery of Medi-Cal health care services to over 800,000 beneficiaries, and it is anticipated that that number may grow significantly in the coming years. CalOptima also has a Medicare-Medi-Cal product, and a Program of All-Inclusive Care for the Elderly (PACE) program, that both continue to grow in membership.

Managed care is a complex, expensive and challenging business. Managed care plans offering predominantly Medi-Cal programs, as well as dual-eligible and PACE programs, are even more complicated to operate because of substantial regulation by both the state and federal government. Managed Medi-Cal plans that are public agencies are also accountable to the public and must comply with the numerous laws regulating public entities in California ("Public Laws"). Public Medi-Cal plans like CalOptima therefore need legal advice and services relating to a wide array of complex and specialized subject matter areas to meet the demands of an ever-changing healthcare and economic environment and operate in an effective and compliant manner.

As part of its strategic planning efforts, the CalOptima Board of Directors ("Board") is considering how best to organize and marshal its legal resources to meet this substantial and increasing demand for legal services. To that end, the Board is exploring the retention of an outside law firm to serve as the agency's general counsel ("CONTRACTOR") to augment, and integrate with, the legal services currently provided by the agency's employed and contracted lawyers. The Board will be requesting information from each law firm who may be interested in applying for such a general counsel role as to its qualifications regarding the anticipated scope of work set forth below.

II. General Requirements.

A. The CONTRACTOR must have substantial experience in representing California managed care organizations ("MCO") that serve predominantly Medi-Cal populations. It must also be able to demonstrate experience representing MCOs serving dual-eligible and PACE program populations.

B. The CONTRACTOR must have an experienced senior lawyer who will serve as the principal and consistent point of contact with CalOptima personnel ("Principal Lawyer"). While it is anticipated that other CONTRACTOR lawyers may work on CalOptima matters from time to time, the Principal Lawyer will be the professional who regularly interacts with the Board, internal lawyers, and management personnel.

C. While it is anticipated that the CONTRACTOR may have multiple offices, the CONTRACTOR must maintain its principal offices in California. The Principal Lawyer must be able to travel to the locations as requested by CalOptima.

III. Strategic Duties.

A. The CONTRACTOR will regularly provide the Board and management with reports on legal trends, issues, and best practices in California and across the healthcare industry, particularly in the public sector domain, that may materially affect CalOptima's business and mission, both currently and in the future.

B. The CONTRACTOR will regularly meet and confer with the Board and management to support CalOptima's strategic planning efforts as an integral member of CalOptima's senior management staff.

IV. Governance Duties.

A. The CONTRACTOR will report to the Board and shall attend all regular and special meetings of the Board, as well as other Board committee meetings by request.

B. The CONTRACTOR will work with internal lawyers to ensure compliance with all Public Laws related to CalOptima's governance.

C. The CONTRACTOR will work with internal lawyers to provide the Board with written summaries of all material legal issues concerning the agency on a regular basis, for monthly board meetings at a minimum.

V. Health Care and Privacy Oversight Duties.

A. The CONTRACTOR will work with CalOptima's compliance personnel and internal lawyers to establish and periodically update CalOptima's health care compliance programs and policies.

B. The CONTRACTOR will regularly attend CalOptima compliance committee meetings.

C. The CONTRACTOR will work with internal lawyers to engage, assist and manage outside compliance counsel and other consultants and support personnel as may be needed from time to time, in connection with investigations, audits, responses to regulatory authorities, and other compliance matters that are not routine.

D. The CONTRACTOR will periodically report to the Board and management regarding any material compliance issues.

VI. Managed Care Regulatory Duties.

A. The CONTRACTOR will work with internal lawyers and outside counsel, where necessary, to ensure compliance with all regulatory requirements of the California Department of Health Care Services, the California Department of Managed Health Care, the federal Center for Medicare & Medicaid Services, and any other governmental entities with jurisdiction over the agency.

B. The CONTRACTOR will periodically report to the Board and management regarding any material regulatory issues.

VII. Managed Care Operations Duties.

A. The CONTRACTOR will work with internal lawyers to ensure that all legal issues related to CalOptima's managed care operations ("Operations Issues") are handled and resolved in a timely and appropriate manner. Operations Issues may involve a broad range of subject matter areas, including without limitation general business operations, payor and provider contracting, credentialing and administration, utilization review and quality assurance, member grievance resolution, provider dispute resolution, vendor contracting, procurement, real estate, intellectual property and technology, Public Laws, risk management and insurance, labor and employment, and general litigation.

B. The CONTRACTOR will work with internal lawyers to engage, assist and manage outside counsel and other consultants and support personnel as may be needed from time to time, to provide legal services in connection with Operations Issues.

C. The CONTRACTOR will periodically report to the Board and management regarding any material Operations Issues affecting the agency.

VIII. Management Duties.

A. The CONTRACTOR will be responsible for managing the overall legal affairs of the agency and coordinating the activities of the internal lawyers and outside legal counsel.

B. The CONTRACTOR will regularly advise the Board about the status of any material legal issues affecting the agency, and will be expected to keep the Board apprised of any legal issues that could adversely or positively affect CalOptima activities.

IX. Out of Scope Items

A. Prior to incurring and fees for the services listed in Section IX, A, i-iii, CONTRACTOR and CalOptima shall agree in writing to agree to these services and potential fees.

i. It may become necessary to for CONTRACTOR to hire experts, consultants or investigators to aid in CalOptima's legal matter. Such persons may be employed by CONTRACTOR on CalOptima behalf. CalOptima agrees to pay for these items in addition to the other CONTRACTOR fees for legal services. All of the costs shall be billed to CalOptima and CalOptima shall be responsible to pay all said costs.

ii. Litigation defense handled by CONTRACTOR.

iii. Defense of CalOptima in administrative proceedings brought by any state or federal agency.

Exhibit B
PAYMENT

A. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR for fees and expenses in accordance with the provisions of this Exhibit and subject to the maximum cumulative payment obligations specified below.

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

C. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 22-10289; 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.

D. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that CalOptima shall pay CONTRACTOR a flat Seventy Thousand Dollars ($70,000) per month, regardless of hours used that month, 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. If the Contract is signed mid-month, CalOptima shall pay a prorated amount equal to Two Thousand Three Hundred Thirty-Three Dollars ($2,333.00) per day for the days active in the first month.

E. Rates:

a. For calculations purposes, CONTRACTOR's hourly billable rate for the $70,000 referenced above shall be One Hundred Ninety-Four Dollars ($194.00) per hour for Three Hundred Sixty (360) Hours of work.
b. If CalOptima exceeds the 360 Hours in any given month, the next Seventy-Five (75) hour will be bill at the same $194.00 per hour.
c. After that, the next 75 hours will be billed at Five Hundred Dollars ($500.00) per hour.
d. If CalOptima exceeds the combined Five Hundred Ten (510) hours outlined above, both parties will discuss in good faith what the rate should be for the remainder of the month.
e. For the items listed in Section IX, Out of Scope Items, of Exhibit A, Scope of Work, CalOptima shall pay CONTRACTOR Five Hundred Dollars ($500.00) per hour.
f. If CalOptima decides to switch from a flat monthly rate to an hourly rate, the hourly rate will be Five Hundred Dollars ($500.00) per hour, and CalOptima needs to give CONTRACTOR 30 days' notice prior to the billing changing.
g. These rates are fixed for the duration of the Contract. CONTRACTOR agrees to extend this rate to CalOptima for a period of one year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

F. CONTRACTOR shall also invoice CalOptima on a monthly basis for travel-related expenses. All expenses charged to CalOptima under this Contract shall be consistent with Exhibit C, CalOptima's Travel Policy. Receipts or reasonable evidence thereof are required for commercial travel, car rental, parking, lodging,

and food. When CONTRACTOR personnel visit more than one client on the same trip, the expenses incurred shall be apportioned in relation to time spent with each client. Travel related expenses shall not exceed Two Thousand Dollars ($2,000.00) per month. CalOptima shall not pay CONTRACTOR for time spent traveling.

G. CONTRACTOR shall also invoice CalOptima on a monthly basis for certain in-house services as outlined in the Engagement Letter. All expenses charged to CalOptima under this Contract shall be consistent with the Engagement Letter. Receipts or reasonable evidence thereof are required. In-House related expenses shall not exceed Five Hundred Dollars ($500.00) per month.

Exhibit B-1

Not applicable for this Contract

Exhibit C

CalOptima Travel Policy

Policy #:	GA.5004	
Title:	**Travel Policy**	
Department:	Finance	
Section:	Purchasing	
CEO Approval:		Michael Schrader MS
Effective Date:	8/1/12	Revised: 9/6/12, 3/1/13
Board Approval:	9/6/12	

I. PURPOSE

To establish a process for reasonable and equitable reimbursement of approved travel and other related expenses incurred by CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants while traveling on authorized CalOptima Business.

II. POLICY

A. For the purpose of this policy, Individual shall mean, unless otherwise specified, all persons authorized to submit an Expense Report, including: CalOptima Board members, CalOptima Standing Committee members, CalOptima employees, and; individuals under contract to CalOptima for which the approved contract provides for reimbursement of travel and/or conference expenses, in accordance with CalOptima rules and regulations.

B. CalOptima shall provide an expense reimbursement process to ensure timely and accurate identification, approval, processing, recording, payment, and monitoring of all necessary travel expenses and miscellaneous expenses incurred by authorized Individuals, in accordance with generally accepted accounting principles (GAAP), and in compliance with State and Federal regulations.

C. CalOptima shall reimburse employees for reasonable expenses incurred while traveling on CalOptima business. All travel must be for the benefit of CalOptima, and must be completed at the most reasonable cost based on the facts and circumstances surrounding the travel. This includes making reservations for air travel and other expenses as soon as possible to access better rates. Employees are expected to use good judgment when traveling, seeking to minimize travel costs whenever possible.

1. Travel Expenses shall include the following items:

   a. Transportation: including commercial carriers, rental vehicles, and mileage for use of personal vehicle;

   b. Lodging;

   c. Meals;

   d. Registration Fees: For attending conferences, seminars, conventions, or meetings of professional societies or community organizations;

   e. Insurance for rental vehicles;

   f. Parking fees and tolls fees (i.e., toll roads and necessary parking);

g. Miscellaneous expenses including:

i. Authorized local and long-distance telephone calls;

ii. Baggage fees;

iii. Internet or Wi-Fi charges;

iv. Facsimiles;

v. Expenses in connection with the preparation of authorized company reports or correspondence;

vi. Taxi or public transit fares, required to conduct business; and

vii. Other unforeseen or unusual expenses that are properly justified and substantiated.

D. Board Member/Standing Committee Member Travel

1. CalOptima shall allow Board members and Standing Committee members reasonable and necessary Travel Expenses and miscellaneous expenses incurred when participating in activities as a member of their respective Board or Committee. Eligible Travel Expenses shall be governed by this policy.

a. The CEO or the Chairperson of the CalOptima Board of Directors, or his or her designee, shall review and approve all Board member and Standing Committee member non-local travel.

b. CalOptima shall limit Board member and Standing Committee member travel to the following purposes:

i. CalOptima business-related activities;

ii. Requests to represent CalOptima as a speaker at an approved meeting, seminar or conference; and

iii. Other travel deemed necessary by the CalOptima Board of Directors.

E. Travel Approval

1. Budgeted Travel: All budgeted Travel and miscellaneous expenses for CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants shall be pre-approved by the appropriate level of CalOptima Management or Board Chair, prior to travel expenses being incurred, according to the following:

Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee
CEO	Board Chairperson or designee
Board Member/Standing Committee Member	Board Chairperson, CEO or designee

2. Non-Budgeted Travel: Non-Budgeted Travel and miscellaneous expenses for authorized Individuals shall be pre-approved by the CEO, or his or her designee, prior to Travel Expenses being incurred.

F. Conferences and Seminars

1. Attendance at any given conference and/or seminar shall be:

   a. Limited to the number of Individuals deemed appropriate by the CEO for that particular conference or seminar, and

   b. Approved by Human Resources.

2. Payment of Fees

   a. Conference and/or seminar fees shall be prepaid whenever possible, to take advantage of early registration discounts. An employee shall request prepayment of conference and seminar fees at the time the Travel and Training Authorization form is prepared, and submit necessary registration information to the Purchasing Department.

   b. In the event an Individual must personally pay for conference or seminar registration fees, the Individual shall request reimbursement on an Expense Report with a pre-approved Travel and Training Authorization Form.

G. Meal Expenses

1. Travel Meals are those food items consumed when traveling on CalOptima Business away from the primary workplace.

2. CalOptima shall reimburse authorized Individuals the actual cost of Travel Meals, excluding alcoholic beverages, in an amount not to exceed forty-five dollars ($45.00) per day, excluding taxes and gratuity.

   a. CalOptima shall reimburse employees and Board members for meals that exceed the forty-five dollars ($45.00) per day under the following conditions:

      i. The authorized Individual shall submit a valid receipt for such meals with a brief explanation of the expenditure. Individual meals shall be subject to the above limitations;

ii. The authorized Individual elects to pay for the meals of individuals with whom authorized CalOptima Business was conducted; or

iii. Extraordinary circumstances may cause it to be impractical or unfeasible for the authorized Individual to stay within the established meal rates, and the authorized Individual shall submit receipts for such meals with a brief explanation of the extraordinary expenditure.

iv. Expense reports containing extraordinary meal expenditures shall require approval of the CEO, or his or her designee.

b. CalOptima may negotiate individual meal per diem amounts for individual contractors authorized to receive reimbursement for expenses, as stipulated in this policy. Individual contractor per diem rates may be less than, but shall not exceed, the established employee, Board and Committee member meal reimbursement rate.

3. CalOptima shall reimburse for Business Meals at actual reasonable and necessary expenses for refreshments or meals, excluding alcoholic beverages, provided in conjunction with on-site or off-site meetings (e.g., in-house developed formal training sessions, conferences, seminars, workshops, staff meetings, and board and commission meetings) which extend over normal breaks or meal periods. An Expense Report for Business Meals must include receipt, names of those in attendance, and the business topic.

H. Lodging Expenses

1. CalOptima shall reimburse the cost of a single room at an Approved Lodging Facility for Non-Local Travel.

2. Adequate lodging expenses will be allowed. Price is an issue in selecting "adequate lodging". Prudence and good stewardship should be used when selecting a lodging facility. Comparison shopping is encouraged; booking through online travel Websites, as opposed to directly with the lodging facility, might provide opportunities for reduced cost lodging. Itemized receipts for lodging must be provided to obtain reimbursement.

3. Travelers should seek lodging rates (excluding taxes and fees) at or below the federal government's per diem rate. If such rates are not available, a hotel's discounted government rate shall be allowed. A schedule of federal lodging per diem rates is available on the U.S. General Services Administration (GSA) Website; www.gsa.gov.

4. CalOptima may reimburse additional lodging expenses for Non-Local Travel if:

a. It results in offsetting lower airfare; and

b. The cost of returning to home or office at the conclusion of business exceeds the cost of lodging, rental automobile and meals for the additional stay.

5. Local Travel may qualify for an overnight stay, depending on time constraints. CalOptima may approve Local Travel lodging expenses if:

a. It is not practical or feasible for the authorized Individual to return home due to extremely poor weather conditions; or

b. Less than eight (8) hours will elapse from the time business is concluded on one (1) day and the time business is scheduled to reconvene on the following calendar day; or

c. It is not practical or feasible for the authorized Individual to return home due to an extended commute.

6. Once approved, the Individual or his or her designee shall be responsible for making his or her own travel and lodging arrangements, utilizing the CalOptima travel services provider or another method approved by CalOptima's Purchasing Department.

7. The Individual shall be responsible for necessary cancellation of travel and lodging reservations, in accordance with the respective rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any cancellations.

I. Cash advances

1. Under normal circumstances, CalOptima shall not issue cash advances for Travel Expenses.

2. The Executive Management team shall approve cash advances for anticipated authorized travel.

3. CalOptima may authorize cash advances on a limited basis if the traveling Individual does not possess sufficient means of credit or other financial resources to cover the cost of one (1) or more authorized Travel Expenses, as defined in this policy.

4. When authorized, cash advances shall be based on an estimate of reasonable Travel Expenses, including travel, meals, lodging and miscellaneous expenses.

5. Individuals receiving cash advances shall complete an Expense Report within five (5) business days of the Individual's return to home or place of work, whichever occurs first. The Individual shall account for all expenses incurred while traveling on authorized CalOptima Business, and shall indicate any cash amounts due back to CalOptima, in the event the cash advance was greater than actual authorized expenses, or cash amounts due the Individual, in the event actual authorized expenses exceed the amount of the cash advance.

J. Transportation

1. The mode of transportation shall be based on the distance of the final destination from the Individual's home or primary workplace, business schedule, and the cost effectiveness of the various modes of transportation.

2. Cost of arrangements for personal travel in conjunction with a business travel itinerary will be at the authorized Individual's expense. The Individual shall document the incremental travel costs assessed to CalOptima, in accordance with this policy.

3. The Individual shall make transportation arrangements as far in advance as possible using the most economical carrier, and the most economical departure point, within the selected mode of transportation. A Saturday night stay may be required to obtain the lowest possible rate, and may be authorized if the savings will reasonably offset the additional cost of meals, automobile rental and lodging.

    a. Flight arrangements made through CalOptima's travel services provider shall be reviewed by CalOptima's Purchasing Department, and submitted directly to Accounts Payable for payment.

    b. Flight arrangements not made through the CalOptima travel services provider shall be submitted by the Individual on an Expense Report.

    c. Individuals may, for personal convenience, travel to their final destination on an indirect route, or on an interrupted direct route, if approved in advance by the CEO. An Individual shall pay any increase in transportation fares based on indirect or interrupted direct travel routes. Any resulting excess travel time shall not be considered work time, but shall be charged to the appropriate type of leave.

    d. Additional expenses shall not be the responsibility of the Individual if, through no fault or control of the Individual, it is necessary to travel an indirect route, or an interrupted direct route. In such cases, additional time shall be considered work time, and shall not be charged to any type of leave.

    e. Whenever available, all Individuals shall travel via "Coach Class," or similar reduced fare accommodations. "Business Class" reservations shall not be used except in the event that "Coach Class" or similar reduced fare accommodations are unavailable, and departure time is critical to the nature of the reason for travel. Under no circumstances shall "First Class" travel be reserved.

    f. Individuals requesting travel reservations shall not insist on any certain commercial carrier if using the specified carrier will result in a fare which is higher than the lowest available fare.

    g. Any deviation from lowest available rate for commercial carriers shall be at the Individual's expense.

4. The Individual shall be responsible for necessary cancellation of travel reservations, in accordance with the respective carrier rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established carrier rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any such cancellations.

5. Use of Privately-Owned Vehicles

    a. An authorized Individual may use a privately-owned vehicle for travel if such use is more economical than the lowest-priced direct commercial carrier fare plus rental car expenses. The Individual must be licensed, and shall carry liability insurance as required by the State of California, at the Individual's sole expense.

b. CalOptima shall reimburse the use of privately-owned vehicles solely based on actual mileage at the Internal Revenue Service (IRS) Standard Mileage Rate. Total mileage reimbursed should consider the Individual's daily commute.

c. CalOptima shall not reimburse costs for fuel, automobile repairs, or other automobile expense items.

d. If more than one authorized Individual is traveling for CalOptima Business in the same personal vehicle, only one person shall be reimbursed for the use of a privately-owned vehicle.

e. Travel shall be by the most practical direct route. Any person traveling by an indirect route shall assume any additional expense incurred.

f. CalOptima shall compensate property damages to an Individual's automobile incurred without fault or cause on the part of the Individual up to two hundred fifty dollars ($250), or the amount of the deductible on the Individual's insurance policy, whichever is the lesser amount, for each accident.

6. Rental Automobiles

a. An Individual may rent automobile when such rental is considered to be more advantageous to CalOptima than other means of transportation.

b. Advance reservations shall be made whenever possible. Reservations for employees, Board and Committee members shall be made in the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

c. The vehicle rental agreement for the authorized Individual shall reference the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

d. Rental automobile approved classes are as follows:

i. Economy Class: An Individual shall select an economy class vehicle whenever four (4) or fewer individuals, including the driver, will be passengers in the rental automobile at any one time.

ii. Mid-size Class: An Individual may select a mid-size class vehicle in the event more than four (4) individuals will be riding in the rental automobile at any one (1) time, or in the event an economy class vehicle is not available, and the nature of the travel requires immediate departure.

iii. Luxury Class: Under no circumstances shall an Individual select a luxury class vehicle.

7. Other Modes of Transportation

a. Taxi Fares: CalOptima shall reimburse taxi fares when public transportation is not practical or available. Examples include travel between hotel and place of business, and from one business to another.

III. PROCEDURE

A. Travel and Training Authorization Form

1. Shall be accessed and completed on-line by all Individuals or their designee using CalOptima's Intranet system (or similar system in place at the time request is made), and shall include all actual or estimated expense amounts related to the request; and

2. Shall be routed for approval systemically based on the Individual's level, cost center, and whether they are a CalOptima employee according to the following:

Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee
CEO	Board Chairperson or designee
Board Member/Standing Committee Member	Board Chairperson, CEO or designee

3. Shall also be routed systemically to the Human Resources Department in order to track the Individual's training.

4. Shall also be routed systemically to the Finance Department for confirmation that requested expenses are budgeted, and that enough budget remains to cover requested expenses.

5. Requestors shall receive an automatic e-mail after submitting their request, notifying them of the approval status, and providing a link to the electronic form to track approval progress.

6. The Purchasing Department shall review, authorize for appropriate approvals, and notify the requestors that they may begin making travel commitments.

B. Travel and Training Arrangements

1. Authorizations that include event registration fees shall be pre-paid and processed by CalOptima's Purchasing Department, where possible. CalOptima's Purchasing Department shall verify with the requestor that the registration has not been processed before proceeding with registration of the Individual for the event.

2. The requestor, or his or her designee, shall make air travel arrangements through CalOptima's travel services provider, where possible. Arrangements should be made as far in advance as possible to minimize costs. Exceptions to using CalOptima's travel services provider are subject to approval by CalOptima's Purchasing Department.

3. All other arrangements shall be made with the Individual's personal credit card, either through CalOptima's travel services provider, another approved method, or directly with the establishment(s), subject to CalOptima's Purchasing Department approval.

C. Expense Reimbursement using Expense Report

1. Individuals or designees shall prepare and submit request claims for reimbursement of Travel Expenses on a CalOptima Expense Report. The report shall be completed by the Individual or designee, including all details, and shall be routed with a copy of the previously-approved Travel and Training Authorization Form for appropriate Expense Report approval signatures, if applicable, as follows:

Individual	**Approver**
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee*
CEO	Board Chairperson or designee*
Board Member/Standing Committee Member	Board Chairperson, CEO or designee*

*Designee authorization is not valid when self approval would result.

2. Receipts

   a. For any expenses in excess of twenty-five dollars ($25.00), the Individual shall include an original credit card receipt, if available, or other computer-generated or hand-written receipt, in the event a credit card receipt is unavailable. CalOptima contractors authorized to receive reimbursement for expenses shall submit receipts for all expenses, regardless of the dollar amount of the expenditure.

   b. Small receipts, such as credit card, gas and airline receipts, shall be attached to an 8 ½ by 11 inch sheet of paper. Hotel receipts and other larger receipts may be submitted as is.

   c. In the absence of credit card receipts, or other proof of actual expenditure, CalOptima shall reimburse lodging expenses only if marked "paid" by the management of the lodging facility.

   d. In most instances, airfare for CalOptima employees and Board members shall be prepaid by CalOptima. CalOptima contractors authorized to receive reimbursement for airfare, and employees and Board members for whom airfare was not prepaid for any reason, shall submit passenger receipts for reimbursement consideration.

   e. If receipts cannot be obtained or have been lost, a statement to that effect shall be made on the Expense Report, along with an appropriate explanation. In the absence of a satisfactory explanation, CalOptima shall not allow the amount.

3. Completed and approved Expense Reports and supporting documentation shall be submitted to the Accounting Department in a timely manner, preferably within thirty (30) days of completion of travel.

4. No reimbursement shall be made for Expense Reports submitted beyond six (6) months after completion of travel.

D. The Accounting Department shall:

1. Review submitted Expense Reports and supporting documentation for completeness;

2. Code expenses to appropriate department and general ledger account numbers; and

3. Process payment for reimbursement.

E. The Purchasing Department shall:

1. Provide travel reports to the CEO, Executive Management, and Department Directors, upon request. Such reports may include a summary of travel by department, purpose, cost, and number of individuals per event, and may be required to distinguish between budgeted and non-budgeted travel.

2. Review details of statements/invoices received from the CalOptima travel services provider for accuracy and reasonableness;

3. Attach appropriate copies of completed Travel and Training Authorization Forms related to travel service provider invoice line items, and submit to Accounts Payable for payment.

4. Review details of statements/invoices received from credit card account used by Purchasing to arrange attendance at conferences, training, and other events, and to make authorized purchases.

5. Attach appropriate copies of completed Travel and Training Authorization Forms related to credit card invoice travel and training line items, and submit to Accounts Payable for payment.

IV. ATTACHMENTS

A. Electronic Travel and Training Authorization Form
B. CalOptima Expense Report
C. Cash Advance Form

V. REFERENCES

A. Internal Revenue Service Publication 463
B. California Government Code Section 53232.2
C. Bylaws of Orange County Health Authority dba Orange Prevention and Treatment Integrated Medical Assistance, Adopted December 6, 1994

VI. APPROVALS OR BOARD ACTION

9/6/12: CalOptima Regular Board Meeting

VII. REVISION HISTORY

A. 9/6/12: GA.5004: Travel Policy
B. 8/1/12: GA.5004: Travel Policy

VIII. KEYWORDS

Approved Lodging
CalOptima Business
Executive Management

Expense Report
Individual
Local Travel
Lodging
Meals
Miscellaneous Expenses
Non-Local Travel
Non-Reimbursable Expenses
Parking, Fees and Tolls
Registration Fees
Reimbursable Expenses
Transportation
Travel
Travel and Training Authorization Form
Travel Expenses

Exhibit D

MEDI-CAL DATA ACCESS AGREEMENT

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

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

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

CONTRACTOR further agrees that this Medi-Cal Data Access Agreement shall remain in full force and effect after the termination of this Contract.

By: _____ Date: 10/26/21

Print Name: JAMES NOVELLO

Title: SHAREHOLDER / PARTNER

_____ 10/27/21

Kelli Kennaday

President

Exhibit E
Part 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

KENNADAY LEAVITT PC
Name of Contractor

JAMES NOVELLO Kelli Kennaday
Printed Name of Person Signing for Contractor

22-10289
Contract/Grant Number

Signature of Person Signing for Contractor

10/26/21
Date

SHAREHOLDER / PARTNER President
Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

Exhibit E

Part 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:	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: ☐ 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:	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*): (*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: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

Exhibit E

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 for this Contract

Exhibit G

ADDENDUM 1
MEDICARE ADVANTAGE PROGRAM

The following additional terms and conditions apply to the provision of goods or services to be utilized, directly or indirectly, by or for the Medicare Advantage Program. These terms and conditions are additive to those contained in the main Contract, and apply to the extent applicable to the services provided by CONTRACTOR. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

A. In addition to compliance with the provisions of Section 8 in the Contract, 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 any and all agreements with CONTRACTOR's subcontractors.

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

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

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

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

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

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

D. For all contracts in the amount of $100,000 or more, in addition to the Equal Opportunity provisions included in the Contract, CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with 41 CFR 60-300.5(a) and 41 CFR 60-741.5(a) as follows:

1. **THIS CONTRACTOR AND SUBCONTRACTOR SHALL ABIDE BY THE REQUIREMENTS OF 41 CFR 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 CFR 60-300.5(d).)

2. **THIS CONTRACTOR AND SUBCONTRACTOR SHALL ABIDE BY THE REQUIREMENTS OF 41 CFR 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 CFR 60-741.5(d).)

E. In addition to the termination provisions of Section 16 of this Contract, CONTRACTOR agrees and acknowledges that 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.

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

G. CalOptima shall review, approve, and audit on an ongoing basis, the credentialing of medical professionals, if any, associated with CONTRACTOR and CONTRACTOR's performance of this Contract.

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

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

Exhibit H

CalOptima

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:	

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:	Kelli Kennaday	Title:	President
Email:	KKennaday@KennadayLewitt.com	Phone #:	916-732-3070
Signature:		Date:	10/27/21

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 I

Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: KENNADAY LEAVITT PC

Business Entity Type: PROFESSIONAL CORPORATION
(Sole Proprietorship, Partnership, LLC, California Corporation, etc.)

Business Address: 621 CAPITOL MALL SUITE 2500

City: SACRAMENTO State: CA Zip: 95814

Business Phone: 916-732-3060 Email: : KKENNADAY @ KENNADAYLEAVITT.COM

President: KELLI KENNADAY Contact Person: JAMES NOVELLO

Person(s) Signing Contract & Title: : JAMES NOVELLO SHARE HOLDER / 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 %
KELLI KENNADAY	PRESIDENT / 28.5%
CURTIS LEAVITT	SECRETARY / 28.5%
TROY SZABO	CFO / TREASURER / 28.5%
JAMES NOVELLO	14.5%

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

Authorized Signature — Date: 10/27/21

Kelli Kennaday, President
Name and Title

Exhibit J

Not applicable for this Contract

Exhibit K

Not applicable for this Contract

Exhibit L

Not applicable for this Contract

Business Associate Agreement

This Business Associate Agreement is entered into by and between the Orange County Health Authority, a California local public agency, doing business as CalOptima ("CalOptima"), and Kennaday Leavitt, PC ("Contractor" or "Business Associate"), effective as of the date last signed below ("Effective Date"). CalOptima and Business Associate are each a party to this Agreement and are collectively referred to as the "parties."

RECITALS

WHEREAS, the parties have executed an agreement(s) whereby Contractor provides services to CalOptima, and Contractor creates, receives, maintains, uses, transmits protected health information ("PHI") in order to provide those services ("Services Agreement(s)");

WHEREAS, as a covered entity, CalOptima is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, Public Law 104-191, and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations (C.F.R.) Parts 160 and Subparts A and E of 45 C.F.R. Part 164 ("Privacy Regulations") and the Security Standards for Electronic Protected Health Information ("Security Regulations") at 45 C.F.R. Parts 160 and Subparts A and C of 45 C.F.R. Part 164, as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") of 2009, Public Law 111-5, and regulations promulgated thereunder including the Breach Notification Regulations at Subpart D of 45 C.F.R. Part 164, and is subject to certain state privacy laws;

WHEREAS, as a business associate, Contractor is subject to certain provisions of HIPAA, and regulations promulgated thereunder, as required by the HITECH Act and regulations promulgated thereunder;

WHEREAS, CalOptima and Business Associate are required to enter into a contract in order to mandate certain protections for the privacy and security of PHI;

WHEREAS, CalOptima's regulator(s) have adopted certain administrative, technical and physical safeguards deemed necessary and appropriate by it/them to safeguard regulators' PHI and have required that CalOptima incorporate such requirements in its business associate agreements with subcontractors that require access to the regulators' PHI;

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

1. **Definitions**. Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in HIPAA, the HITECH Act, and regulations promulgated thereunder.

   1.1. **Agreement** as used in this document means both this Business Associate Agreement and the Services Agreement to which this Business Associate Agreement applies, as specified in such Services Agreement.

   1.2. **Breach** means, unless expressly excluded under 45 C.F.R. § 164.402, the acquisition, access, use, or disclosure of PHI in a manner not permitted under Subpart E of 45 C.F.R. Part 164 which compromises the security or privacy of the PHI and as more particularly defined under 45 C.F.R. § 164.402.

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1.3. **Business associate** has the meaning given such term in 45 C.F.R. § 160.103.

1.4. **Confidential information** refers to information not otherwise defined as PHI in Section 1.15 below, but to which state and/or federal privacy and/or security protections apply.

1.5. **Data aggregation** has the meaning given such term in 45 C.F.R. § 164.501.

1.6. **Designated record set** has the meaning given such term in 45 C.F.R. § 164.501.

1.7. **Disclose** and **disclosure** mean the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

1.8. **Electronic health record** has the meaning given such term in 42 U.S.C. § 17921.

1.9. **Electronic media** means:

1.9.1. Electronic storage material on which data is or may be recorded electronically including, for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

1.9.2. Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet, extranet or intranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

1.10. **Electronic protected health information** ("ePHI") means individually identifiable health information that is transmitted by or maintained in electronic media.

1.11. **Health care operations** has the meaning given such term in 45 C.F.R. § 164.501.

1.12. **Individual** means the person who is the subject of PHI and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.13. **Individually identifiable health information** means health information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual, as set forth under 45 C.F.R. § 160.103.

1.14. **Information system** means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally

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includes hardware, software, information, data, applications, communications, and people.

1.15. **Protected health information** ("PHI"), as used in this Agreement and unless otherwise stated, refers to and includes both PHI as defined at 45 C.F.R. § 160.103 and personal information ("PI") as defined in the Information Practices Act at California Civil Code § 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

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

1.17. **Secretary** means the Secretary of the U.S. Department of Health and Human Services or the Secretary's designee.

1.18. **Security incident** means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

1.19. **Services** has the same meaning as in the Services Agreement(s).

1.20. **Unsecured protected health information** ("unsecured PHI") means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary in the guidance issued under 42 U.S.C. § 17932(h)(2).

1.21. **Use** and **uses** mean, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination or analysis of such information within the entity that maintains such information.

2. CalOptima intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute PHI and/or confidential information protected by federal and/or state laws.

3. Contractor is the business associate of CalOptima acting on CalOptima's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of CalOptima, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, "use or disclose PHI") in order to fulfill Business Associate's obligations under this Agreement.

4. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement on behalf of CalOptima, provided that such use or disclosure would not violate HIPAA, including the Privacy Regulations, if done by CalOptima.

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

4.2. **Data Aggregation**. If authorized as part of the services provided to CalOptima under the Services Agreement, Business Associate may use PHI to provide data aggregation services relating to the health care operations of CalOptima.

5. **Prohibited Uses and Disclosures of PHI**

5.1. **Restrictions on Certain Disclosures to Health Plans**. Business Associate shall not Disclose PHI about an individual to a health plan for payment or health care operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full and the individual requests such restriction in accordance with HIPAA and the HITECH Act, including 45 C.F.R. § 164.522(a). The term PHI, as used in this Section, only refers to PHI as defined in 45 C.F.R. § 160.103.

5. 2. **Prohibition on Sale of PHI; No Remuneration**. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written authorization of CalOptima and CalOptima's regulator(s), as applicable, and then, only as permitted by HIPAA and the HITECH Act. The term PHI, as used in this Section, only refers to PHI as defined in 45 C.F.R. § 160.103.

6. **Compliance with Other Applicable Law**

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

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

6.1.2. To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 17 of this Agreement.

6.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 1 of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code §§

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1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, Welfare and Institutions Code § 5328, and California Health and Safety Code § 11845.5.

6.3 If Business Associate is a Qualified Service Organization ("QSO") as defined in 42 C.F.R. § 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 C.F.R. § 2.11.

7. **Additional Responsibilities of Business Associate**

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

7.2. **Safeguards and Security**

7.2.1. Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with Subpart C of 45 C.F.R. Part 164 with respect to ePHI, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be, at a minimum, at Federal Information Processing Standards (FIPS) Publication 199 protection levels. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of Subpart C of 45 C.F.R. Part 164, in compliance with 45 C.F.R. § 164.316. Business Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities.

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

7.2.2.1. NIST SP 800-53 - National Institute of Standards and Technology Special Publication 800-53

7.2.2.2. FedRAMP - Federal Risk and Authorization Management Program

7.2.2.3. PCI - PCI Security Standards Council

7.2.2.4. ISO/ESC 27002 - International Organization for Standardization / International Electrotechnical Commission standard 27002

7.2.2.6. IRS PUB 1075 - Internal Revenue Service Publication 1075

7.2.2.7. HITRUST CSF - HITRUST Common Security Framework

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7.2.3. Business Associate shall maintain, at a minimum, industry standards for transmission and storage of PHI and other confidential information, including, but not limited to, encryption of all workstations, laptops, and removable media devices containing PHI and data transmissions of PHI.

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

7.2.5. Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

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

7.3. **Minimum Necessary**. With respect to any permitted use, disclosure, or request of PHI under this Agreement, Business Associate shall make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of such use, disclosure, or request respectively, as specified in 45 C.F.R. § 164.502(b).

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

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

9. **Access to PHI**. Except as otherwise provided in Section 9.1 below, Business Associate shall, to the extent CalOptima determines that any PHI constitutes a designated record set, make the PHI specified by CalOptima available to the individual(s) identified by CalOptima as being entitled to access and copy that PHI. Business Associate shall provide such access for inspection of that PHI within fifteen (15) calendar days after receipt of request from CalOptima. Business Associate shall also provide copies of that PHI ten (10) calendar days after receipt of request from CalOptima. If Business Associate maintains an electronic health record with PHI, and an individual requests a copy of such information in electronic format, Business Associate shall make such information available in that format as required under the HITECH Act and 45 C.F.R. § 164.524(c)(2)(ii).

9.1. **Business Associate of CalOptima PACE**. This Section applies when Contractor is a business associate of CalOptima in CalOptima's capacity as a health care provider through CalOptima Program of All-Inclusive Care for the Elderly ("CalOptima PACE"). Business Associate shall, to the extent CalOptima determines that any PHI constitutes a designated record set or patient records (as defined in California Health and Safety Code § 123105), make the PHI specified by CalOptima available to the individual(s) identified by CalOptima as being entitled to access and copy that PHI. To enable compliance with California Health & Safety Code § 123110 and 45 C.F.R. § 164.524, Business Associate

shall provide such access for inspection of that PHI within three (3) working days after receipt of request from CalOptima. Business Associate shall also provide copies of that PHI ten (10) calendar days after receipt of request from CalOptima. If Business Associate maintains an electronic health record with PHI, and an individual requests a copy of such information in electronic format, Business Associate shall make such information available in that format as required under the HITECH Act and 45 C.F.R. § 164.524(c)(2)(ii).

10. **Amendment of PHI**. Business Associate shall, to the extent CalOptima determines that any PHI constitutes a designated record set, make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526 as requested by CalOptima in the time and manner designated by CalOptima.

11. **Accounting of Disclosures**. Business Associate shall document and make available to CalOptima or (at the direction of CalOptima) to an individual, such disclosures of PHI and information related to such disclosures, necessary to respond to a proper request by the subject individual for an accounting of disclosures of PHI in accordance with HIPAA, the HITECH Act and implementing regulations. Unless directed by CalOptima to make available to an individual, Business Associate shall provide to CalOptima, within thirty (30) calendar days after receipt of request from CalOptima, information collected in accordance with this Section to permit CalOptima to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. The term PHI, as used in this Section, only refers to PHI as defined in 45 C.F.R. § 160.103. Any accounting provided by Business Associate under this Section shall include:

    11.1. The date of the disclosure;

    11.2. The name, and address if known, of the entity or person who received the PHI;

    11.3. A brief description of the PHI disclosed; and

    11.4. A brief statement of the purpose of the disclosure.

    For each disclosure that could require an accounting under this Section, Business Associate shall document the information enumerated above, and shall securely maintain the information for six (6) years from the date of the disclosure (but beginning no earlier than April 14, 2003).

12. **Compliance with HITECH Act**. Business Associate shall comply with the requirements of Title XIII, Subtitle D, of the HITECH Act, which are applicable to business associates, and shall comply with the regulations promulgated thereunder.

13. **Compliance with Obligations of CalOptima or DHCS**. To the extent Business Associate is to carry out an obligation of CalOptima or the California Department of Healthcare Services ("DHCS") under 45 C.F.R. Part 164, Subpart E, Business Associate shall comply with the requirements of such Subpart that apply to CalOptima or DHCS, as applicable, in the performance of such obligation.

14. **Access to Practices, Books and Records**. Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of CalOptima available to CalOptima upon reasonable request, and to the DHCS and the Secretary for purposes of determining CalOptima's compliance with 45 C.F.R. Part 164, Subpart E. Business Associate

also agrees to make its internal practices, books and records relating to the use and disclosure of PHI on behalf of CalOptima available to DHCS, CalOptima, and the Secretary for purposes of determining Business Associate's compliance with applicable requirements of HIPAA, the HITECH Act, and implementing regulations. Business Associate shall immediately notify CalOptima of any requests made by DHCS or the Secretary and provide CalOptima with copies of any documents produced in response to such request.

15. **Return or Destroy PHI on Termination; Survival**. At termination of this Agreement, if feasible, Business Associate shall return to CalOptima or, if agreed to by CalOptima, destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, CalOptima that Business Associate or its agents or subcontractors still maintains in any form, and shall retain no copies of such information. If CalOptima elects destruction of PHI and/or other confidential information, Business Associate shall ensure such information is destroyed in accordance with the destruction methods specified in Sections 15.1 and 15.2 below, and shall certify in writing to CalOptima that such information has been destroyed accordingly. If return or destruction is not feasible, Business Associate shall notify CalOptima of the conditions that make the return or destruction infeasible. Subject to the approval of CalOptima's regulator(s) if necessary, if such return or destruction is not feasible, CalOptima shall determine the terms and conditions under which Business Associate may retain the PHI. Business Associate shall also extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

15.1 **Data Destruction**. Data destruction methods for CalOptima PHI or confidential information must conform to U.S. Department of Defense standards for data destruction DoD 5220.22-M (7 Pass) standard or by degaussing. Media may also be physically destroyed in accordance with NIST Special Publication 800-88. Other methods require prior written permission of CalOptima and, if necessary, CalOptima's regulator(s).

15.2 **Destruction of Hard Copy Confidential Data**. CalOptima PHI or confidential information in hard copy form must be disposed of through confidential means, such as cross cut shredding and pulverizing.

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

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

17.1. **Notice to CalOptima**

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

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17.1.2. **24-Hour Notice**. Business Associate shall notify CalOptima within 24 hours by email (or by telephone if Business Associate is unable to email CalOptima) of the discovery of:

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

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

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

17.1.2.4. Potential loss of confidential data affecting this Agreement.

17.1.3. Notice shall be provided to the CalOptima Privacy Officer ("CalOptima Contact") using the CalOptima Contact Information at Section 17.7 below. Such notification by Business Associate shall comply with CalOptima's form and content requirements for reporting privacy incident and shall include all information known at the time the incident is reported.

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

17.2.1. Prompt action to mitigate any risks or damages involved with the security incident or breach;

17.2.2. Any action pertaining to such unauthorized disclosure required by applicable federal and state law; and

17.2.3. Any corrective actions required by CalOptima or CalOptima's regulator(s).

17.3. **Investigation**. Business Associate shall immediately investigate such security incident or confidential breach. Business Associate shall comply with CalOptima's additional form and content requirements for reporting such privacy incident.

17.3.1. Incident details including the date of the incident and when it was discovered;

17.3.2. The identification of each individual whose unsecured PHI has been, or is reasonably believed by Business Associate to have been accessed, acquired, used or disclosed during the breach;

17.3.3. The nature of the data elements involved and the extent of the data involved in the breach;

17.3.4. A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data;

17.3.5. A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized;

17.3.6. A description of the probable causes of the improper use or disclosure;

17.3.7. Any other available information that the Business Associate is required to include in notification to the individual under 45 C.F.R. § 164.404(c);

17.3.8. Whether the PHI or confidential data that is the subject of the security incident, breach, or unauthorized use or disclosure of PHI or confidential data included unsecured PHI;

17.3.9. Whether a law enforcement official has requested a delay in notification of individuals of the security incident, breach, or unauthorized use or disclosure of PHI or confidential data because such notification would impede a criminal investigation or damage national security and whether such notice is in writing; and

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

17.4. **Complete Report**. Business Associate shall provide a complete written report of the investigation ("Final Report") to the CalOptima Contact within seven (7) working days of the discovery of the security incident or breach. Business Associate shall comply with CalOptima's additional form and content requirements for reporting of such privacy incident.

17.4.1. The Final Report shall provide a comprehensive discussion of the matters identified in Section 17.3 above and the following:

17.4.1.1. An assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and state laws;

17.4.1.2. A full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure and to reduce the harmful effects of the breach;

17.4.1.3. The potential impacts of the incident, such as potential misuse of data, identity theft, etc.; and

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

17.4.2. If CalOptima or CalOptima's regulator(s) requests additional information, Business Associate shall make reasonable efforts to provide CalOptima with such information. A supplemental written report may be used to submit revised or additional information after the Final Report is submitted.

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17.4.3. CalOptima and CalOptima's regulator(s), as applicable, will review and approve or disapprove Business Associate's determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

17.4.4. **New Submission Timeframe**. If Business Associate does not complete a Final Report within the seven (7) working day timeframe specified in Section 17.4 above, Business Associate shall request approval from CalOptima within the seven (7) working day timeframe of a new submission timeframe for the Final Report. Business Associate acknowledges that a new submission timeframe requires the approval of CalOptima and, if necessary, CalOptima's regulator(s).

17.5. **Notification of Individuals**. If the cause of a breach is attributable to Business Associate or its agents, then CalOptima or, as required by CalOptima, Business Associate shall notify individuals accordingly. The notifications shall comply with applicable federal and state law. All such notifications shall be coordinated with CalOptima. CalOptima and CalOptima regulator(s), as applicable, shall approve the time, manner and content of any such notifications. Business Associate acknowledges that such review and approval by CalOptima and CalOptima regulator(s), as applicable, must be obtained before the notifications are made.

17.6. **Responsibility for Reporting of Breaches to Entities Other than CalOptima**. If the cause of a breach of PHI is attributable to Business Associate or its subcontractors, Business Associate agrees that CalOptima shall make all required reporting of the breach as required by applicable federal and state law, including any required notifications to media outlets, the Secretary, and other government agency/regulator.

17.7. **CalOptima Contact Information**. To direct communications to CalOptima Privacy Officer, the Business Associate shall initiate contact as indicated here. CalOptima reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

CalOptima Privacy Office

Privacy Officer
c/o: Office of Compliance
CalOptima
505 City Parkway West
Orange, CA 92868

Email: privacy@caloptima.org

Telephone: (714) 246-8400 (ask the operator to connect to Privacy Officer)

18. **Responsibilities of CalOptima**

18.1 CalOptima agrees to not request the Business Associate to use or disclose PHI in any

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manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

18.2 **Notification of SSA Data**. CalOptima shall notify Business Associate if Business Associate receives data that is SSA data from or on behalf of CalOptima.

19. **Indemnification**. Business Associate will immediately indemnify and pay CalOptima for and hold it harmless from (i) any and all fees and expenses CalOptima incurs in investigating, responding to, and/or mitigating a breach of PHI or confidential information caused by Business Associate or its subcontractors or agents; (ii) any damages, attorneys' fees, costs, liabilities or other sums actually incurred by CalOptima due to a claim, lawsuit, or demand by a third party arising out of a breach of PHI or confidential information caused by Business Associate or its subcontractors or agents; and/or (iii) for fines, assessments and/or civil penalties assessed or imposed against CalOptima by any government agency/regulator based on a breach of PHI or confidential information caused by Business Associate or its subcontractors or agents. Such fees and expenses may include, without limitation, attorneys' fees and costs and costs for computer security consultants, credit reporting agency services, postal or other delivery charges, notifications of breach to individuals, and required reporting of breach. Acceptance by CalOptima of any insurance certificates and endorsements required under the Service Agreement(s) does not relieve Business Associate from liability under this indemnification provision. This provision shall apply to any damages or claims for damages whether or not such insurance policies shall have been determined to apply.

20. **Audits, Inspection and Enforcement**

20.1. From time to time, CalOptima or CalOptima's regulator(s) may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the CalOptima Privacy Officer in writing. Whether or how CalOptima or CalOptima's regulator(s) exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

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

21. **Termination**

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

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

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

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

22. **Miscellaneous Provisions**

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

22.2. **Amendment**

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

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

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

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

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

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

22.7. **Statutory or Regulatory Reference**. Any reference to statutory or regulatory language in this Agreement shall be to such language as in effect or as amended.

22.8. **Injunctive Relief**. Notwithstanding any rights or remedies provided in this Agreement, CalOptima retains all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of PHI or confidential information by Business Associate or any agent, subcontractor, employee or third party that received PHI or confidential information.

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EXECUTION

Subject to the execution of a Services Agreement or amendments thereto by Business Associate and CalOptima, this Business Associate Agreement shall become effective on the Effective Date.

In witness thereof, the parties have executed this Business Associate Agreement:

Kennaday Leavitt, PC	CalOptima
JAMES NOVELLO Print Name	Print Name
Signature	Signature
SHAREHOLDER / PARTNER Title	Title
10/26/21 Date	Date
Kelli Kennaday Print Name	Print Name
Signature	Signature
President Title	Title
10/27/21 Date	Date

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
9. Consider Approval of an Executive Employment Agreement and Agreement Terms for a Temporary (Interim) Chief Executive Officer.

Contact
Brigette Hoey, Executive Director, Human Resources (714) 246-8405

Recommended Action(s)
Approve the amended motion to appoint Michael Hunn as Temporary (Interim) Chief Executive Officer, with an annual salary of $560,000, $550 monthly car allowance, 28 days of annual Paid Time Off (PTO), all other employee benefits approved by the Board; and authorized the Chairman to execute the ~~Executive~~ Employment Agreement. ~~for a Temporary (Interim) Chief Executive Officer.~~

Rev. 11/4/2021

Background
On September 9, 2021, CalOptima's Chief Executive Officer (CEO), Richard Sanchez provided his notice of resignation and informed the Board of Directors that his last day of service with CalOptima will be November 7, 2021.

At the October 7, 2021, meeting, the Board of Directors acted to amend the CEO's employment agreement to increase the base salary to $560,000, the minimum of the salary range for the CEO position. The Board had previously authorized funds from reserves to implement revisions to the Salary Schedule on September 2, 2021.

Discussion
Mr. Sanchez's departure will leave a vacancy in CalOptima's highest executive leadership position. To provide day-to-day leadership during the search for CalOptima's next CEO, it is recommended that an Interim CEO be appointed by the Board to carry out the day-to-day administrative functions and to meet all regulatory requirements that an individual be designated/identified to serve in the capacity of CEO.

Michael Hunn has been working with CalOptima since July 2021 to provide organizational leadership consulting services and management support for critical initiatives including California Advancing and Innovating Medi-Cal (CalAIM) and the Centers for Medicare & Medicaid Services (CMS) audit remediation. Approval of the attached Executive Employment Agreement with Mr. Hunn for the position of Temporary (Interim) CEO, effective November 8, 2021, will fill the CEO position on a temporary basis while the Board considers appointment of a permanent CEO. Upon approval of this action, CalOptima will terminate the current agreement with Hunn Group, LLC, effective November 4, 2021.

Fiscal Impact
The recommended action to approve the Executive Employment Agreement for the Temporary (Interim) CEO is budget neutral. The annual fiscal impact of the Agreement is $560,000 in base salary. Since there is no overlap in effective dates, budgeted funds for salaries and benefits under the CalOptima

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Fiscal Year (FY) 2021-22 Operating Budget approved by the Board on June 3, 2021, and subsequent Board actions, are sufficient to cover projected expenses associated with the agreement for the period of November 8, 2021, through June 30, 2022.

Rationale for Recommendation

Approval of an Interim CEO contract is recommended to meet regulatory requirements and ensure the continued smooth operations of CalOptima and coverage for CEO responsibilities on an interim basis until the Board of Directors appoints a permanent CEO.

Attachments

1. Executive Employment Agreement

/s/ Richard Sanchez *10/29/2021*

Authorized Signature **Date**

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INTERIM EXECUTIVE EMPLOYMENT AGREEMENT

THIS INTERIM EXECUTIVE EMPLOYMENT AGREEMENT ("Agreement") is made and entered into effective November 8, 2021 ("Effective Date") by and between, the Orange County Health Authority, dba Orange Prevention and Treatment Integrated Medical Assistance, dba CalOptima ("Employer" or "CalOptima") and Michael Hunn ("Employee"). Employer and Employee are collectively referred to herein as the “Parties” or singularly as a “Party.”

RECITALS

WHEREAS, Employer is a Health Authority and local public agency responsible for administering a county operated health system for the provision of health care services to individuals qualifying for various government-funded health care programs; and

WHEREAS, Employee has executive health care and other relevant experience, and the Board of Directors ("Board") believes that it is in the best interest of CalOptima that Employee be named the Interim Chief Executive Officer; and

WHEREAS, Employee is willing to accept such employment on the terms and conditions set forth in this Agreement below.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained in this Agreement, it is hereby agreed as follows:

AGREEMENT

1. Employment:

    a. Subject to CalOptima’s satisfactory completion of background and reference checks, Employee shall serve as the Interim Chief Executive Officer ("CEO") of CalOptima during the term of this Agreement. Employee will perform such duties as are customarily performed by CEOs of like organizations and as may be assigned from time to time by the Board. These duties shall include working closely with the Board to establish internal policies, structures and procedures and to promote cooperative relationships with local, state and federal officials and agencies in support of CalOptima programs. In performing his duties, Employee will abide by all applicable federal, state, and local laws as well as CalOptima's bylaws, rules, regulations and policies as may be amended from time to time.

    b. Employee shall devote during normal business hours, at a minimum, his full time, ability and attention to Employer's business during the term of this Agreement and use his best efforts to promote CalOptima’s interests. Employee is expected to engage in the hours of work to the business of Employer that are necessary to fulfill the obligations of the position, be available at all times, and devote time in excess of the regularly established workday or in excess of a forty (40) hour work period which may include time outside normal office hours. Employee will generally be expected to keep office hours at CalOptima Monday through Friday during normal business hours. Employee shall not directly or indirectly acquire, hold, or retain any interest in any business competing with or similar in nature to the business of

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Employer or which in any other way creates a conflict of interest. During the term of this Agreement, Employee shall not in any way engage or participate in any business that is in competition with Employer. Employee will comply with all provisions of CalOptima Policy GA.8012: Conflicts of Interest.

c. Employee acknowledges that in the course of his employment contemplated herein, Employee will be given or will have access to confidential and proprietary documents and information relating to CalOptima, its operations, employees, providers, and members. ("Confidential Information") Employee acknowledges and agrees that the sale, unauthorized use or disclosure of any of Employer's Confidential Information or trade secrets constitutes unfair competition and a violation of applicable laws or CalOptima policies, and that Employee will not engage in any unauthorized disclosure of Confidential Information or unfair competition with Employer, either during the term of this Agreement or thereafter. Employee further acknowledges and agrees that for one year following separation from CalOptima, Employee will not actively recruit, solicit, or offer employment to any then current CalOptima employee on behalf of Employee, or any other employer, agency, or organization.

d. Employer may fix other terms and conditions of employment, as it may determine from time to time, relating to the performance of Employee, provided such terms and conditions are not inconsistent with or in conflict with the provisions of this Agreement or applicable law.

2. Term:
   a. CalOptima agrees to employ Employee and Employee accepts employment with CalOptima on an interim basis from the effective date of this Agreement through June 30, 2022, continuing thereafter on a month-to-month basis, subject to the termination provisions in accordance with this Agreement.

3. Salary and Benefits:
   a. Salary: Beginning on the effective date of this Agreement, Employee will receive a Base Annual Salary of five hundred sixty thousand dollars ($560,000) payable in equal installments according to the Employer's regular payroll schedule, less any applicable taxes and withholding. Employer shall also deduct sums Employee is obligated to pay because of participation in plans or programs described in Paragraph 3.c. of this Agreement. Base compensation is subject to annual review by the Board. Merit increases, if any, will be determined by the Board at a future date(s).

   b. Car Allowance: Employer will provide Employee with $550 per month to be used as an automobile allowance. Employee will be responsible for all operating expenses of his automobile as well as for procuring and maintaining automobile liability insurance.

   c. Benefits: Employee is entitled to participate in all employee benefit programs and plans established by CalOptima from time to time for the benefit of its employees generally, and for which Employee is eligible. Employee shall also receive the following:

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i. To the extent permitted under applicable law, (a) Employer will pay for Employee's portion of contributions to his CalPERS ("PERS") retirement plan under the applicable PERS formula and legal limitations, if applicable; and (b) Employer will make supplemental Public Agency Retirement System ("PARS") retirement contributions based on the same percentage applicable to all employees, subject to wage and other limits under applicable laws.

ii. At Employee's option, Employer will (a) provide term life insurance in the amount of the Employee's annual salary, or (b) pay Employee an amount equal to the premium for such life insurance.

iii. In addition to the PTO provided on the Effective Date of this Agreement, Employee shall accrue PTO at a rate of twenty-eight (28) days per year (prorated on a bi-weekly basis).

d. Expenses:

i. Employee will be reimbursed for the cost of all reasonable expenses incurred by Employee for CalOptima business, so long as the expenses are incurred and submitted according to Employer's expense reimbursement policies and procedures and supported by documentation meeting the Employer's standard requirements.

4. Termination of Employment:

a. Employee is an at-will employee appointed by and serving at the pleasure of the Board of Directors. CalOptima, acting through the Board, may terminate this Agreement and Employee's employment at any time with or without Cause. Nothing herein, however, shall be construed to create a property interest, where one does not exist by rule of law, in the position of Interim Chief Executive Officer. CalOptima shall have no obligation to pay for the remaining days and/or months left on the unexpired Term of this Agreement, and Employee expressly agrees that he shall not be entitled to any severance pay as a result of the termination of this Agreement.

b. Employee may terminate this Agreement and Employee's employment at any time upon sixty (60) days advance written notice. Such advance written notice may be waived by the Board and the termination by the Employee may be accepted immediately.

c. In the event CalOptima appoints a permanent CEO to commence employment prior to the expiration of this Agreement, CalOptima will provide thirty (30) days advance written notice in accordance with Section 4.a.

d. Notwithstanding the foregoing, Government Code section 53260 provides that all contracts of employment with a local agency must include a provision limiting the maximum cash settlement for the termination of the contract to the monthly salary (excluding benefits) multiplied by the number of months left on the unexpired term, but not more than 18 months if the unexpired term exceeds 18 months. Accordingly, should severance payment subsequently be provided, it shall not exceed the amount authorized to be paid under Government Code section 53260.

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5. Indemnification. Consistent with the California Government Code, Employer shall defend and indemnify Employee, using legal counsel of Employer's choosing, against expense or legal liability for acts or omissions by Employee occurring within the course and scope of Employee's employment under this Agreement. In the even there is a conflict of interest between Employer and Employee in such a case so that independent counsel is required for Employee, Employer may select the independent counsel after having considered the input of Employee and shall pay the reasonable fees of such independent counsel. If Employee is convicted of a crime involving abuse of his position as defined in Government Code section 53243.4, Employee shall reimburse Employer for all legal defense fees and costs.

6. Withholding of Taxes: CalOptima will withhold from any monies payable pursuant to this Agreement all federal, state, city or other taxes as may be required by any law, governmental regulation or ruling.

7. Notices: Notices and all other communications under this Agreement shall be in writing and shall be deemed given when personally delivered or when mailed by U.S. registered or certified mail, return receipt requested, postage prepaid, addressed as follows

   If to the Employer:

   CalOptima
   505 City Parkway West
   Orange, California 92868
   Attention: Chair, Board of Directors

   If to the Employee:

   Michael Hunn

8. Waiver of Breach: The waiver by either Party, or the failure of either Party to claim a breach of any provision of this Agreement, shall not operate or be construed as a waiver of any subsequent breach.

9. Assignment: The rights and obligations of the respective Parties hereto under this Agreement shall inure to the benefit of and shall be binding upon the heirs, legal representatives, successors and assigns of the Parties hereto; provided, however, that this Agreement shall not be assignable by either Party without prior written consent of the other Party.

10. AB 1344: Assembly Bill 1344, which was subsequently enacted as Government Code sections 53243 - 53243. 4, instituted certain limitations on compensation paid to local government executives. These statutes require that contracts between local agencies and its employees include provisions requiring an employee who is convicted of a crime involving an abuse of his office or position to provide reimbursement to the local agency for the following forms of payment: (i) paid leave salary; (ii) criminal defense costs; (iii) cash settlement payments; and (iv) any non-contractual settlement payments. Accordingly, the Parties agree that it is their mutual intent to fully comply with these Government Code sections and all other applicable law, as may be amended from time to time. Specifically, the

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following Government Code sections are called out and hereby incorporated by this Agreement: (1) 53243 - Reimbursement of paid leave salary required upon conviction of crime involving office or position; (2) 53243. 1 - Reimbursement of legal criminal defense upon conviction of crime involving office or position; (3) 53243. 2 - Reimbursement of cash settlement upon conviction of crime involving office or position; (4) 53243. 3 - Reimbursement of noncontractual payments upon conviction or crime involving office or position; and (5) 53243. 4 - "Abuse of office or position" defined. Employee has reviewed, is familiar with, and agrees to comply fully with each of these provisions if any of these provisions are applicable to Employee, including that Employee agrees that any cash settlement or severance related to the termination that Employee may receive from CalOptima shall be fully reimbursed to CalOptima if Employee is convicted of a crime involving an abuse of his or her office or position.

11. Entire Agreement: This Agreement sets forth the final, complete and exclusive agreement between the Parties relating to the employment of Employee by Employer, and supersedes any and all other agreements, either oral or in writing, between the Parties hereto with respect to the subject matter hereof and contains all of the covenants and agreements between the Parties with respect to said subject matter in any manner whatsoever. Any modification of this Agreement will be effective only if it is in writing and signed by both Employee and the Board Chairman of the CalOptima. The foregoing notwithstanding, Employee acknowledges that, except as expressly provided in this Agreement, his employment is subject to the Employer's generally applicable rules and policies pertaining to employment matters, such as those addressing equal employment opportunity, harassment and violence in the workplace, as they currently or may in the future exist, and his employment is, and will continue to be, at the will of the Board.

12. No Liability of the County of Orange: As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the Parties hereto acknowledge and agree that the obligations of CalOptima under this Agreement are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability hereunder.

13. Governing Law: This Agreement shall be governed by, construed and enforced 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.

14. Partial Invalidity: If any provision of this Agreement is found to be invalid or unenforceable by any court, the remaining provisions hereof shall remain in effect unless such partial invalidity or unenforceability would defeat an essential business purpose of this Agreement.

15. Independent Review. Employee acknowledges that he has had the opportunity and has conducted an independent review of the financial and legal effects of this Agreement. Employee acknowledges that he has made an independent judgment upon the financial and legal effects of this Agreement and has not relied upon any representation of CalOptima, its officers, agents or employees other than those expressly set forth in this Agreement. Employee acknowledges that he has been advised to obtain, and has available himself of, legal advice with respect to the terms and provisions of this Agreement.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be duly executed and

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delivered on the 4th day of November 2021, at Orange County, California.

ORANGE COUNTY HEALTH AUTHORITY

Employer: By:_____
Andrew Do, Chairman

Employee: By:_____
Michael Hunn

_____

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Approval of New Finance Policy FF.4002: Special Payments: Enhanced Care Management Supplemental Payment for Capitated Health Networks

Contact

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

Recommended Action

Approve new CalOptima Policy FF.4002: Special Payments: Enhanced Care Management Supplemental Payment for Capitated Health Networks

Background

On January 8, 2021, the Department of Health Care Services (DHCS) released a revised California Advancing and Innovating Medi-Cal (CalAIM) proposal that takes a whole-person care approach to improving health outcomes for Medi-Cal members by incorporating both clinical and nonclinical services. Implementation of CalAIM initiatives by managed care plans spans five years, beginning January 1, 2022. Two key CalAIM initiatives are Enhanced Care Management (ECM) and Community Supports. ECM creates a single, intensive, and comprehensive benefit that is designed to meet the needs of CalOptima's most vulnerable members. Community Supports are medically appropriate, cost-effective alternatives that are provided as a substitute for services covered under the California Medicaid State Plan and are delivered by a different provider or in a different setting than those described in the State Plan. ECM and Community Supports are optional for members.

CalOptima and delegated health networks will provide ECM services, and the current Whole Person Care (WPC) and Health Homes Program (HHP) providers will deliver Community Supports. For the initial launch of CalAIM and to ensure a smooth transition for WPC and HHP members, CalOptima will offer the following Community Supports currently offered through the County's WPC and CalOptima's HHP: housing transition navigation services, housing tenancy and sustaining services, housing deposits, and recuperative care (i.e., medical respite).

Following the initial January 1, 2022, implementation of ECM and Community Supports, CalOptima plans to explore expanding the network of providers and Community Supports offerings and will return to this Board for future consideration. This new finance policy applies to one component of CalAIM implementation, the ECM benefit.

Discussion

CalOptima establishes new and modifies existing policies and procedures to implement federal and state laws, programs, regulations, contracts, and business practices. In addition, CalOptima staff performs an annual policy review to add or update internal policies and procedures to ensure compliance with applicable requirements.

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Below is a list of substantive areas in the policy. There is no redline document available, as this is a new policy.

Policy Section	Proposed Change	Rationale	Impact
All	Establish new ECM supplemental payment policy for capitated health networks	Creates internal policy to address financial operations to implement the new ECM benefit for ECM eligible members that are enrolled in health networks	No additional fiscal or operational impact
Purpose	This policy defines the criteria for a delegated health network, acting as an ECM provider to receive a supplemental payment for ECM services	N/A	N/A
Policy	This section sets payment conditions and member exclusions	N/A	N/A
Procedure	This section provides more details on how to submit claims and handle overpayments and provider disputes	N/A	N/A

Under the policy, each Health Network will submit a billing for each Member authorized for ECM services and will receive a fixed payment for each Member that received at least the minimum amount of ECM services during that month. Staff recommends approval of the new CalOptima Policy FF.4002 with an effective date of January 1, 2022.

Fiscal Impact

The recommended action to approve CalOptima Policy FF.4002 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget approved by the Board on June 3, 2021.

Rationale for Recommendation

The recommended action will enhance the efficiency of CalOptima's operations and governance and ensure compliance with applicable regulatory requirements.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Policy FF.4002: Special Payments: Enhanced Care Management Supplemental Payment for Capitated Health Networks

/s/ Richard Sanchez *10/28/2021*
Authorized Signature **Date**

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Policy:	FF.4002
Title:	**Special Payments: Enhanced Care Management Supplemental Payment for Capitated Health Networks**
Department:	Finance
Section:	Accounting
CEO Approval:	*/s/*
Effective Date:	01/01/2022
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the criteria for a delegated Health Network, acting as an Enhanced Care Management (ECM) Provider, to receive a supplemental payment for ECM services provided to an ECM-eligible Member, including outreach services to Members included in "Populations of Focus" as prescribed by the Department of Health Care Services (DHCS).

II. POLICY

A. Effective for dates of service on or after January 1, 2022, CalOptima shall make an ECM Supplemental Payment to Health Networks acting as a contracted ECM Provider at rates set forth in the Contract for Health Care Services, in accordance with the terms and conditions of this Policy.

B. CalOptima shall issue an ECM Supplemental Payment when all the following conditions are met:

1. Member is identified as an ECM-eligible Member in accordance with CalOptima Policy GG.1354: Enhanced Care Management - Eligibility and Outreach;

2. The delegated Health Network has authorized the ECM services; and

3. ECM services are billed and reported to CalOptima in accordance with Section III.A. of this policy, consistent with the most recent state or regulatory guidance and using the national standard specifications and code sets, as defined by DHCS.

C. A Member shall not be eligible for ECM benefits while enrolled in the following programs:

1. 1915(c) waivers, including Multipurpose Senior Services Program (MSSP);

2. Fully integrated programs for members dually eligible for Medicare and Medi-Cal including Cal MediConnect program or Program for All-Inclusive Care for the Elderly (PACE); or

3. Basic or complex case management programs.

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D. In the event DHCS or CalOptima identifies that a Member did not agree to receive, was not qualified for, or was not authorized to receive ECM services, CalOptima shall recover any ECM Supplemental Payments made to the Health Network for that Member.

III. PROCEDURE

A. Health Network Claims Submission

1. The Health Network shall bill for all ECM services rendered by a qualified professional.

2. To qualify for the ECM Supplemental Payment, the Health Network shall bill on a monthly basis, between the first (1) and the fifteenth (15) day of the month, for ECM services rendered in the previous month.

   a. One claim per member per month shall be submitted;

   b. Claims shall be billed in unit measurements for procedure codes associated with ECM services, as defined by DHCS;

   c. Each unit shall represent a fifteen (15) minute interval;

   d. CalOptima shall pay a Per Enrollee Per Month ECM Supplemental Payment for each Health Network Member authorized to receive ECM services who receives three (3) or more hours of ECM services in a given month as identified by twelve (12) or more units billed; and

   e. In order to ensure adequate data collection on ECM services, a claim shall be submitted for each Health Network Member eligible for ECM services, regardless of whether those services reached the three (3)-hour supplemental payment threshold for the month being reported.

B. CalOptima shall process a claim in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible.

C. If a Health Network identifies an overpayment of the ECM Supplemental Payment, the Health Network shall return the overpayment to CalOptima in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible.

D. A Health Network may file a provider dispute regarding an ECM Supplemental Payment in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy GG.1354: Enhanced Care Management - Eligibility and Outreach
D. CalOptima Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible
E. CalOptima Policy HH.1101: CalOptima Provider Complaint

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VI. REGULATORY AGENCY APPROVAL(S)

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

VII. BOARD ACTION(S)

Date	Meeting
11/04/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2022	FF.4002	Special Payments: Enhanced Care Management Supplemental Payment for Capitated Health Networks	Medi-Cal

IX. GLOSSARY

Term	Definition
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC), a physician group under a shared risk contract, or HMO, and DHCS Medi-Cal Managed Care Division Policy Letters.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
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 Provider	Providers within the community that have a contractual relationship with CalOptima (delegated Health Networks), or CalOptima acting directly (COD), to provide ECM services to Members authorized to receive ECM. ECM Providers have experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members enrolled in that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program.
Per Enrollee Per Month	An all-inclusive case rate that applies whenever a provider has provided at least the minimum level of ECM services to an enrolled Member. This rate is paid on the basis of submitted claims and is not to be considered a capitation payment.

Term	Definition
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 into 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

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Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Approval of Program Year 1 CalAIM Performance Incentive Payment Methodology for All Health Networks, Except AltaMed Health Services Corporation, Arta Western California, Inc., Monarch Health Plan, Inc., and Talbert Medical Group, P.C.

Contact

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

Recommended Actions

1. Approve Program Year (PY) 1 CalAIM Performance Incentive Payment Methodology for the Medi-Cal line of business for all health networks, except AltaMed Health Services Corporation, Arta Western California, Inc., Monarch Health Plan, Inc., and Talbert Medical Group, P.C. that defines measures and allocations effective January 1, 2022, through December 31, 2022;
2. Authorize the allocation and distribution of CalAIM Program Incentive Dollars for PY 1 to CalOptima and delegated health networks in accordance with the recommended methodology in an aggregate amount for all health networks not to exceed $45.0 million; and
3. Authorize funding for and the distribution of incentive payments prior to CalOptima's receipt of CalAIM Program Incentive Dollars from the State of California.

Background

In preparation for the start of CalAIM's Enhanced Care Management (ECM) and In Lieu of Services (ILOS) programs on January 1, 2022, the California Department of Health Care Services (DHCS) will provide managed care plans with performance incentives to promote provider participation and capacity building. The state budget includes funding for incentive payments beginning on January 1, 2022 and ending in Fiscal Year (FY) 2024-25. Specifically, the state budget includes an allocation of $300 million for plan incentives from January 1, 2022, through June 30, 2022; $600 million for FY 2022-23; and $600 million for FY 2023-24. The incentive funding will phase out in FY 2024-25.

The initial PY 1 funding priority areas include:

- Delivery System Infrastructure;
- ECM Provider Capacity Building;
- ILOS Provider Capacity Building and managed care plan take-up; and
- Quality "Pay for Reporting" measures (which will be incorporated in the ECM provider capacity and ILOS provider capacity building priorities).

For PY 1, the state budget includes a $600 million allocation. DHCS plans to set a cap on the potential incentive dollars managed care plans may earn each program year and will provide a breakdown of the dollars across each priority area. These amounts will be based on total managed care enrollment and revenue. The actual payments earned by a plan in PY 1 will be based on the achievement of DHCS-specified "Gate" and "Ladder" milestones.

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Discussion

In order to properly assess the delivery system infrastructure and ECM and ILOS provider capacity in Orange County, CalOptima is required to submit a "Gap Assessment and Gap Filling Plan" in Fall 2021. This plan will report to DHCS on baseline data and outlines CalOptima's implementation plan to address the identified gaps and needs. Attachment 2 provides information on DHCS' proposed milestones and measures.

DHCS Funding

On September 28, 2021, DHCS informed CalOptima that the amount of potential incentive dollars for PY 1 is approximately $45.0 million. This funding level accounts for the already existing Whole Person Care (WPC) and Health Homes Program (HHP) infrastructure in Orange County. DHCS plans to divide the timing of the PY 1 payments and the requirements for earning such payments into two (2); the first in January 2022 and the second in December 2022.

Payment 1: Anticipated January 2022

CalOptima management anticipates receiving half of the potential incentive amount or approximately $22.5 million in January 2022. DHCS intends managed care plans to use prepaid dollars to implement the activities outlined in the Gap Filling Plan. As such, CalOptima will need to complete the specified "Gate" requirements and report back to DHCS in Fall 2021. If CalOptima fails to make a minimum level of effort to implement their Gate-Filling Plan, DHCS reserves the right to recoup a portion of the prepaid funding.

Payment 2: December 2022

CalOptima management anticipates receiving the second half of the potential incentive amount or $22.5 million in December 2022. The state will measure CalOptima's performance against targets linked to the achievement of measures in the Gap Filling Plan (i.e., "Ladder" measures). CalOptima will need to report these measures to DHCS in Fall 2022 based on activities completed from January through June 2022.

CalOptima, in its capacity as a managed care plan, shall retain a portion of the incentive funding for retained ILOS risk. Staff estimates PY 1 funding of up to $14.5 million for this purpose. Up to $30.5 million in incentive funding will be distributed to health networks.

Health Networks

CalOptima Direct Networks (CCN/COD)

CCN/COD will be subject to the same allocation criteria as those described below.

Delegated Health Networks (HMO, PHC, SRG)

To ensure adequate revenue to support provider participation and capacity building, CalOptima will distribute incentive dollars consistent with DHCS guidance, based on the assumed delegated risk under

CalAIM and contingent on the maximum potential incentive dollars as communicated by DHCS. CalOptima will employ the following to make incentive payments to delegated health networks.

Payment 1: A health network must be in good standing with CalOptima at the time of disbursement. Eligible health networks shall receive as prefunding, an allocation of the amount of incentive dollars available. This allocation will take into account the anticipated delivery system infrastructure and ECM and ILOS provider capacity, as well as the level of delegated responsibility.

- CalOptima will distribute each health network's allocation upon completion of a final calculation. The allocation will include a fixed component of $250,000 per health network and variable components based on the health network's projected proportion by "populations of focus," as defined by DHCS; and
- CalOptima, at its sole discretion, may make annual or more frequent payments to health networks.

A health network shall submit a completed attestation form, signed by its Chief Executive Officer or Chief Financial Officer. CalOptima will provide a form that each health network can use to attest to the level of spending by PY 1 funding priority area. The health network's allocation of incentive dollars is as follows:

- 30% to Delivery System Infrastructure;
- 30% to ECM Provider Capacity Building;
- 15% to ILOS Provider Capacity Building; and
- 25% to health network discretion to one or more of the above priority areas.

Each health network shall participate in data collection, reporting activities and data submission to CalOptima, including measures for the Gap Assessment and Gap-Filling Plan and other subsequent data reporting requested by CalOptima. As of this writing, DHCS continues to develop and finalize guidance for the implementation of ECM and ILOS, including policy guidance for incentive payments and data sharing. Staff will return to the Board with additional information on measures and health network data sharing requirements pursuant to DHCS final guidance.

Payment 2: To qualify for funding, a health network must be in good standing with CalOptima at the time of disbursement.

- CalOptima will distribute each health network's allocation upon completion of a final calculation. The allocation will be based on demonstrated performance against measure targets and the projected health network proportion by "populations of focus," as defined by DHCS; and
- CalOptima, at its sole discretion, may make annual or more frequent payments to health networks.

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Each health network shall participate in data collection, reporting activities and data submission to CalOptima, including measures for the "Ladder" measures and other subsequent data reporting requested by CalOptima.

In the event DHCS recoups any portion of the incentive funding due to a lack of effort to implement or to demonstrate performance against measure targets, CalOptima reserves the right to make subsequent recoupments from health networks. A health network shall participate in taking corrective actions and submitting updates to CalOptima on process measures identified by DHCS through a corrective action plan to CalOptima.

Fiscal Impact

The fiscal impact of the PY 1 CalAIM performance incentive for the Medi-Cal line of business for January 1, 2022, through December 31, 2022, is projected to be budget neutral to CalOptima. The aggregate amount payable to all CalOptima and delegated health networks is not anticipated to exceed $45.0 million for PY 1. Staff anticipates any cash expended for the provider incentive payments will be replenished when CalAIM performance incentive dollars are received from DHCS.

Rationale for Recommendation

The recommended actions will enable CalOptima to support provider participation and capacity building in preparation of CalAIM ECM and ILOS programs.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. DHCS Proposed Milestones and Measures for CalAIM Incentive Payments (Draft for stakeholder feedback dated August 30, 2021)
3. CalAIM Performance Incentives (Draft for stakeholder feedback dated June 30, 2021)

/s/ Richard Sanchez *10/28/2021*

Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima Medi-Cal Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
AMVI Care Health Network	600 City Parkway West Ste. 800	Orange	CA	92868
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	5785 Corporate Ave.	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

DHCS

Proposed Milestones and Measures for CalAIM Incentive Payments
DRAFT - August 30, 2021

Priority	Percentage of Dollars (i.e., Max Cap) Allocated to Priority Area	Points Needed to Earn Max Payment 1	Points Needed to Earn Max Payment 2
1. Delivery System Infrastructure	Minimum 20%	200	200
2. ECM Provider Capacity Building	Minimum of 20%	200	200
3. ILOS Provider Capacity Building and ILOS Take-Up	Minimum of 30%	300	300
4. Quality	Optional measures with values allocated to either ECM or ILOS	N/A	To be allocated to ECM or ILOS based on measure
Total Points		700	700
MCP Discretion to Allocate to One or More Priority Areas	Up to 30% of Max Cap to be added to one or more of the above priority areas based on discretion of the plan, as reported in the Gap-Filling Plan template		

MCPs are required to submit information pertaining to the measures noted as mandatory, and can select among additional optional measures, to earn up to their full cap. DHCS will evaluate the MCP submissions and award payments proportional to the number of points earned per measure (as specified in the Reporting Template).MCPs are permitted and encouraged to work closely with providers and other stakeholders on these measures.

High Performance Pool: MCPs will receive payments from the high performance pool based on their performance against their individualized targets for each of their quantitative requirements reported as part of the submission for Payment 2. MCPs must meet minimum requirements to be eligible to earn high performance pool dollars, including:
-- Report on all mandatory requirements for the Gap/Need Assessment and Gap Filling Plan;
-- Offer at least three ILOS, and;
-- Demonstrate a minimum level of effort to implement their Gap-Filling Plan (i.e., are not placed on a corrective action plan).

Priority	Payment 1 Measures	Target for Payment 1 Measures	Optional / Mandatory for Payment 1	Weighting for Payment 1 Measures (Points Out of 700 Across Domains)	Payment 2 Measures	Target for Payment 2 Measure	Optional / Mandatory for Payment 2 Measures	Weighting for Payment 2 Measures (Points Out of 700 Across Domains)	Measure to Determine if Payment 1 is Fully Earned (i.e., Not Subject to Recoupment)?
1. Delivery System Infrastructure	Number and percent of contracted ECM Providers capable of electronically exchanging care plan information and clinical documents with other care team members	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted ECM Providers capable of electronically exchanging care plan information and clinical documents with other care team members	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Number and percent of contracted ECM Providers with access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted ECM Providers with access to certified EHR technology or a care management documentation systems able to generate and manage a patient care plan	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Number and percent of contracted ECM and ILOS Providers who are capable of submitting a claim or invoice to an MCP, or have access to a system or service that can process and send a claim or invoice to an MCP with information necessary for the MCP to submit a compliant encounter to DHCS	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted ECM and ILOS providers capable of submitting a claim or invoice to a MCP, or have access to a system or service that can process and send a claim or invoice to a MCP with information necessary for the MCP to submit a compliant encounter to DHCS	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Number and percent of contracted ILOS Providers for those ILOS offered by the MCP starting January 1, 2022 or July 1, 2022 who have access to closed-loop referral systems	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted ILOS Providers for those ILOS offered by the MCP starting January 1, 2022 or July 1, 2022 with access to closed-loop referral systems	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Number and percent of contracted behavioral health providers able to electronically exchange care plan information and clinical documents with other care team members	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted behavioral health providers able to electronically exchange care plan information and clinical documents with other care team members	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Submission of a narrative or joint MOU describing how the MCP will collaborate with other MCPs in the county to enhance and develop needed ECM/ILOS infrastructure, including certified EHR technology, care management document systems, closed-loop referral, billing systems/services, and onboarding/enhancements to health information exchange capabilities and submission of documentation demonstrating good faith efforts to begin this collaboration in the form of letters with MCPs in county, emails demonstrating progress, meeting meetings, or other documentation. If only one MCP is operating in the county, the MCP must submit a narrative describing how they will leverage and expand existing WPC capacity and support ongoing ECM and ILOS capacity building approaches	See reporting template for evaluation criteria for MOU	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Narrative describing how the MCP successfully collaborated with other MCPs in the county to enhance and develop needed ECM/ILOS infrastructure, including certified EHR technology, care management document systems, closed-loop referral, billing systems/services, and onboarding/enhancements to health information exchange capabilities	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Submission of a narrative Gap-Filling plan describing how MCPs will identify underserved populations and the ECM providers they are assigned to, and enhance those ECM Providers' capabilities to: (1) Electronically exchange care plan information and clinical documents with other care team members (2) Have access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan. (3) Submit a claim or invoice to an MCP, or have access to a system or service that can process and send a claim or invoice to an MCP with information necessary for the MCP to submit a compliant encounter to DHCS MCPs should also describe any plans to build physical plant infrastructure (e.g., sobering centers) to support the launch of ECM and ILOS. Gap-Filling Plan narrative should include approaches for collaborating with, Social Services, County Behavioral Health, and County/Local Public Health Agencies within the county to achieve the above activities, and should describe how health plans will leverage existing WPC infrastructure, including how they will track the ongoing viability of WPC infrastructure and improve data integration across behavioral health and physical health providers	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	80	Submission of a narrative demonstrating progress against Gap-Filling Plan, including identification of underserved populations and the ECM providers they are assigned to, and enhancements that have been made to those ECM Providers' capabilities to: (1) Electronically exchange care plan information and clinical documents with other care team members (2) Have access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan. (3) Submit a claim or invoice to an MCP, or have access to a system or service that can process and send a claim or invoice to an MCP with information necessary for the MCP to submit a compliant encounter to DHCS MCPs should also describe any progress to build physical plant infrastructure (e.g., sobering centers) to support the launch of ECM and ILOS. Narrative should outline progress on collaborations with Social Services, County Behavioral Health, and Counties/Local Public Health Agencies within the county to achieve the above activities, and should describe how health plans have leveraged existing WPC infrastructure and improved data integration across behavioral health and physical health providers.	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	80	**Yes**
2. ECM Provider Capacity Building	Number of contracted ECM Providers	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	20	Number of contracted ECM Providers	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	20	No
2. ECM Provider Capacity Building	Number of members identified as eligible to transition from HHP/WPC to ECM	N/A - Pay for Reporting	**Optional,** Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 points	Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 Points	Number of Members receiving ECM	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	10	No
2. ECM Provider Capacity Building	Number of Members across Program Year 1 Populations of Focus expected to require ECM. Break out of Members across Program Year 1 Populations of Focus expected to require ECM by race, ethnicity, and primary language.	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	10	Number of Members across Program Year 1 Populations of Focus receiving ECM. Break out of Members across Program Year 1 Populations of Focus receiving ECM by race, ethnicity, and primary language.	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	10	No
2. ECM Provider Capacity Building	Submission of a narrative or joint MOU describing how the MCP will collaborate with other MCPs in the county to support expansion of ECM Provider capacity, including leveraging and expanding existing WPC capacity and building/expanding ECM Provider networks and compliance and oversight capabilities. MCP should also submit documentation demonstrating good faith efforts to begin this collaboration in the form of letters with MCPs in county, emails demonstrating progress, meeting meetings, or other documentation. If only one MCP is operating in the county, the MCP must submit a narrative describing how they will leverage and expand existing WPC capacity and support ongoing ECM capacity building approaches	See reporting template for evaluation criteria for MOU	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	10	Narrative describing how the MCP successfully collaborated with other MCPs in the county to support ECM Provider capacity expansion, and leverage existing WPC capacity. If only one MCP is operating in the county, the narrative must describe how they successfully leveraged and expanded existing WPC capacity to support ECM capacity building	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	20	No
2. ECM Provider Capacity Building	Narrative summary that outlines landscape of Providers, faith-based groups, and community based organizations in the county and submission of a narrative plan to develop an MOU or other agreements with a subset of Providers, faith-based groups, county agencies and community based organizations in the county to develop strategies for closing health disparities experienced by Populations of Focus, including agreement to meet at least quarterly to advance strategy	See reporting template for evaluation criteria for narrative summary	**Optional,** Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 points	Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 Points	Submission of MOU or other collaborative agreement, associated agenda and meeting notes and narrative description of progress against narrative plan submitted as part of Payment 1 measure for the strategic partnership with the MCP, Providers, faith-based groups, county agencies and community based organizations to a develop strategy for closing health disparities experienced by Populations of Focus	See reporting template for evaluation criteria for MOU	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building	Narrative summary that outlines landscape of Tribes and Tribal providers used by members in the county and submission of a narrative plan to develop an MOU to establish a strategic partnership with Tribes and Tribal providers used by members in county to develop Provider capacity and provision of ECM services for members of Tribes	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 1 Tied to ECM Provider Capacity, except for Plans in Counties without recognized Tribes	30	Submission of MOU or other collaborative agreement, associated agenda and meeting notes and narrative description of progress against narrative plan submitted as part of Payment 1 measure, to demonstrate progress made to work with Tribes and Tribal providers used by members in county on Provider capacity and provision of ECM services for members of Tribes in county	See reporting template for evaluation criteria for MOU	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	20	No

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Priority	Payment 1 Measures	Target for Payment 1 Measures	Optional / Mandatory for Payment 1	Weighting for Payment 1 Measures (Points Out of 700 Across Domains)	Payment 2 Measures	Target for Payment 2 Measure	Optional / Mandatory for Payment 2 Measures	Weighting for Payment 2 Measures (Points Out of 700 Across Domains)	Measure to Determine if Payment 1 is Fully Earned (i.e., Not Subject to Recoupment)?
2. ECM Provider Capacity Building	Submission of narrative plan describing how the managed care plan will improve outreach to and engagement with the following Population of Focus: "*people experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless with complex health and/or behavioral health conditions,* " with a focus on Black/African American and other racial and ethnic groups who are disproportionately experiencing homelessness	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	30	Baseline data for individuals who are Black/African American and from other racial and ethnic groups who are disproportionately experiencing homelessness and who meet the Population of Focus definition: "*people experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless with complex health and/or behavioral health conditions* " **and narrative summary** of progress the MCP made to improve outreach to and engagement with individuals who are Black/African American and other racial and ethnic groups who are disproportionately experiencing homelessness	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	20	No
2. ECM Provider Capacity Building	Submission of narrative plan describing how the managed care plan will improve outreach to and engagement with the following Population of Focus: "individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of sevices to the community," with a focus on Black/African American and other racial and ethnic groups who are disproportionately experiencing transitions from incarceration settings in the county	See reporting template for evaluation criteria for narrative summary	**Optional,** Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 points	Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 Points	Baseline data for individuals who are Black/African American and from other racial and ethnic groups who disproportionately meet the Population of Focus definition: "*individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community* " who have been successfully outreached to and engaged by an ECM Provider and **narrative summary** of progress the MCP made to improve outreach to and engagement with Black/African American and other racial and ethnic groups who are disproportionately experiencing transitions from incarceration settings	N/A - Pay for Reporting	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building	Reporting on racial and ethnic demographics of ECM Providers for each Program Year 1 Populations of Focus relative to the racial and ethnic demographics of the Members in each Program Year 1 Populations of Focus	N/A - Pay for Reporting	**Optional,** Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 points	Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 Points	Reporting on racial and ethnic demographics of ECM Providers for each Program Year 1 Populations of Focus relative to the racial and ethnic demographics of the beneficiaries in the Program Year 1 Populations of Focus	N/A - Pay for Reporting	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building					Hired full time Health Equity Officer by July 1, 2022 who has the necessary qualifications or training at the time of hire or within 1 year of hire to meet the requirements of the position, as outlined in the MCP Procurement	N/A - Pay for Reporting	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building					Rates of sharing ECM assessment and care plan information across physical and behavioral health care teams	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	10	No
2. ECM Provider Capacity Building	Submission of a narrative Gap-Filling plan describing: (1) How the MCP will address identified gaps in ECM Provider capacity for Program Year 1 Populations of Focus (2) Identified ECM workforce, training, TA needs in county, including specific cultural competency needs by county (3)Plan for ECM Provider workforce recruiting and hiring of necessary staff to build capacity (4) Approach for MCP to develop and administer an MCP training and TA program for ECM Providers (5) Strategy to ensure ECM Providers are successfully engaging with hard to reach Populations of Focus, including homeless and justice involved populations, among others Gap-Filling Plan narrative should include approach for collaborating with Social Service, County Behavioral Health, County/Local Public Health Agencies, Tribes and Tribal providers (except for Plans in Counties without recognized Tribes), community based organizations and ECM Providers to achieve the above activities, improve outreach to and engagement with hard to reach individuals within each Populations of Focus and reduce underlying health disparities	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	70	Submission of a narrative describing progress against Gap-Filling plan, including: (1) Progress in increasing ECM Provider capacity and MCP oversight capacity (1) Progress in addressing ECM workforce, training, TA needs in county, including specific cultural competency needs by county (2) Progress in supporting ECM Provider workforce recruiting and hiring of necessary staff to build capacity (3) Progress in developing and administering a MCP training and TA program for ECM Providers (4) Progress in successfully engaging with hard to reach Populations of Focus, including homeless and justice involved populations, among others Narrative should outline progress and results from collaborations with County Social Service, Behavioral Health, County/Local Public Health Agencies, Tribes and Tribal providers (except for Plans in Counties without recognized Tribes), community based organizations and ECM Providers to achieve the above activities, improve outreach to and engagement with hard to reach individuals within each Populations of Focus and reduce underlying health disparities.	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	60	**Yes**
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Plan All-Cause Readmissions (PCR)** For beneficiaries ages 18 to 64 who are in the ECM populations of focus, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: • Count of Index Hospital Stays (IHS) • Count of Observed 30-Day Readmissions • Count of Expected 30-Day Readmissions	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Ambulatory Care—Emergency Department Visits (AMB-ED)** Rate of emergency department (ED) visits per 1,000 beneficiary months for beneficiaries who are in the ECM populations of focus	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Depression Screening and Follow-Up for Adolescents and Adults (DSF)** The percentage of beneficiaries 12 years of age and older who are in the ECM populations of focus and who were screened for clinical depression using a standardized tool and, if screened positive, who received follow-up care.	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)** The percentage of members 12 years of age and older with a diagnosis of depression, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Follow-Up After Emergency Department Visit for Mental Illness (FUM)** Percentage of emergency department (ED) visits for beneficiaries age 18 and older who are in the ECM populations of focus and who have a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)** Percentage of emergency department (ED) visits for beneficiaries age 18 and older who are in the ECM populations of focus and have a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: • Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) • Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Controlling High Blood Pressure (CBP)** Percentage of beneficiaries ages 18 to 85 who are in the ECM populations of focus and who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)** Percentage of children ages 1 to 17 who are in the ECM populations of focus and who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: • Percentage of children and adolescents on antipsychotics who received blood glucose testing • Percentage of children and adolescents on antipsychotics who received cholesterol testing • Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
3. ILOS Provider Capacity Building and ILOS Take-Up	Number of contracted ILOS Providers	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up	20	Number of contracted ILOS Providers	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	20	No

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Priority	Payment 1 Measures	Target for Payment 1 Measures	Optional / Mandatory for Payment 1	Weighting for Payment 1 Measures (Points Out of 700 Across Domains)	Payment 2 Measures	Target for Payment 2 Measure	Optional / Mandatory for Payment 2 Measures	Weighting for Payment 2 Measures (Points Out of 700 Across Domains)	Measure to Determine if Payment 1 is Fully Earned (i.e., Not Subject to Recoupment)?
3. ILOS Provider Capacity Building and ILOS Take-Up	Number of members identified as eligible to transition from HHP/WPC to ILOS	N/A - Pay for Reporting	**Optional,** Report on One Optional Payment 1 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 50 points	Report on One Optional Payment 1 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 50 Points	Number of Members receiving ILOS	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	20	No
3. ILOS Provider Capacity Building and ILOS Take-Up	Offer ILOS housing suite: housing transition navigation, housing deposits, housing tenancy and sustaining services, short-term post-hospitalization housing, day habilitation programs, and medical respite starting in January 2022 or July 2022	N/A - MCPs must offer the full ILOS housing suite to earn incentive dollars tied to this measure	**Optional,** Report on One Optional Payment 1 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 50 points	Report on One Optional Payment 1 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 50 Points					
3. ILOS Provider Capacity Building and ILOS Take-Up	Number of ILOS offered county-wide by the MCP starting January 2022 or July 2022 *If the ILOS Provider network/capacity will not reasonably allow for county-wide provision of ILOS to all eligible Members in the county at the time of implementation, please provide additional information in the Gap-Filling Plan. DHCS will review the information provided to determine if the county-wide provision of a given ILOS is not a reasonable expectation and work with the MCP to assess if a given ILOS not offered county-wide will count toward this measure.*	Evaluated based on number of ILOS offered county-wide: 1-4 = 60 points 5-7 = 70 point 8+ = 80 points	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up	Points awarded based on number of ILOS offered: 1-4 = 60 points 5-7 = 70 point 8+ = 80 points					
3. ILOS Provider Capacity Building and ILOS Take-Up	Narrative summary that outlines landscape of Tribes and Tribal providers used by members in the county and submission of a narrative plan to develop an MOU to establish a strategic partnership with Tribes and Tribal providers used by members in county to develop Provider capacity and provision of provision of ILOS for members of Tribes in county	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up, except for Plans in Counties without recognized Tribes	20	Submission of MOU or other collaborative agreement, associated agenda and meeting notes and narrative description of progress against narrative plan submitted as part of Payment 1 measure, to demonstrate progress made to work with Tribes and Tribal providers used by members in county on Provider capacity and provision of ILOS for members of Tribes and Tribal providers used by members in county	See reporting template for evaluation criteria for MOU	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	20	No
3. ILOS Provider Capacity Building and ILOS Take-Up					Percent of enrollees receiving ILOS by race, ethnicity, and primary language, relative to the demographics in the underlying enrollee population	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	50	No
3. ILOS Provider Capacity Building and ILOS Take-Up	Submission of a narrative or joint MOU describing how the MCP will collaborate with other MCPs in the county to leverage and expand existing WPC capacity and support ongoing ILOS capacity building approaches. MCP should also submit documentation demonstrating good faith efforts to begin this collaboration in the form of letters with MCPs in county, emails demonstrating progress, meeting meetings, or other documentation. If only one MCP is operating in the county, the MCP must submit a narrative describing how they will leverage and expand existing WPC capacity and support ongoing ILOS capacity building approaches	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up	50	Narrative describing how the MCP successfully collaborated with other MCPs in the county to leverage and expand existing WPC capacity and support ongoing ILOS capacity building approaches. If only one MCP is operating in the county, the MCP must submit a narrative describing how they successfully leveraged and expanded existing WPC capacity to support ongoing ILOS capacity building approaches.	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	50	No
3. ILOS Provider Capacity Building and ILOS Take-Up	Submission of a narrative Gap-Filling plan describing: (1) Identified gaps or limitations in ILOS coverage within county (2) Plan to increase number and/or reach of ILOS offered in January 2022 or July 2022 (3) Identified ILOS Provider capacity and MCP oversight capability gaps and plan to address gaps (4) Identified ILOS workforce, training, TA needs in region / county, including specific cultural competency needs by region/county (5) Plan to develop and administer a training and TA program for ILOS Providers (6) Plan to establish programs to support ILOS workforce recruiting and hiring, including incentives for ILOS Providers to hire necessary staff Gap-Filling Plan narrative should include approach for collaborating with Social Service, County Behavioral Health, County/Local Public Health Agencies, and ILOS Providers to achieve the above activities, improve outreach to and engagement with hard to reach individuals and reduce underlying health disparities.	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up	80	Submission of a narrative demonstrating progress against Gap-Filling plan, including: (1) Reduced gaps or limitations in ILOS coverage across county (2) Increased number and/or reach of ILOS offered in January 2022 or July 2022 (3) Reduction in ILOS Provider capacity and MCP oversight capability gaps (4) Resolution of ILOS workforce, training, TA needs in region / county, including specific cultural competency needs by region/county (5) Successfully administered training and TA program for ILOS Providers (6) Demonstrated support for ILOS workforce recruiting and hiring Narrative should outline progress and results from collaborations with County Social Service, Behavioral Health, County/Local Public Health Agencies, and ILOS Providers to achieve the above activities, improve outreach to and engagement with hard to reach individuals, and reduce underlying health disparities.	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	120	Yes
3. ILOS Provider Capacity Building and ILOS Take-Up *Quality Measure*					**Submission of baseline data for Asthma Medication Ratio** The percentage of beneficiaries ages 5 to 64 who are receiving ILOS, 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	N/A - Pay for Reporting in CY 2022	**Optional,** Report on One Optional Payment 2 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 20 points	Report on One Optional Payment 2 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 20 Points	No

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CalAIM Performance Incentives

DRAFT for Stakeholder Feedback

June 30, 2021

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Agenda

- Overview of Incentive Payment Approach
- Allocation Methodology and Timing
- Payment Priorities and Measure Domains
- High Performance Pool
- Consequences for Failure to Meet Requirements of "Gate Payment Advance"
- Questions

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Overview

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CalAIM Performance Incentives Overview

CalAIM's Enhanced Care Management (ECM) and In Lieu Of Services (ILOS) programs will launch in January 2022, requiring significant new investments in care management capabilities, ILOS infrastructure, information technology (IT) and data exchange, and workforce capacity at both the managed care plan (MCP) and provider levels.

- Incentive payments will be a critical component of CalAIM to promote MCP and provider participation in, and capacity building for, ECM and ILOS.
- The Governor's budget allocated $300 million for plan incentives from January to June 2022, $600 million from July 2022 to June 2023, and $600 million from July 2023 to June 2024. Incentive funding will phase out in FY 2024-25.
- DHCS has designed the proposed incentive payment approach with input from stakeholders with the goal of issuing initial payments to MCPs beginning in January 2022 for the achievement of defined milestones.

Performance Incentive Goals

- **Build appropriate and sustainable ECM and ILOS capacity**
- **Drive MCP investment in necessary delivery system infrastructure**
- **Incentivize MCP take-up of ILOS**
- **Bridge current silos across physical and behavioral health delivery**
- **Reduce health disparities and promote health equity**
- **Achieve improvements in quality performance**

Infrastructure development, ECM and ILOS Provider capacity building, and ILOS take-up are priority areas for Program Year (PY)1 (i.e., Calendar Year (CY) 2022). DHCS will incorporate behavioral and physical health integration and health disparities reduction measures within those priority areas.

Quality "pay for reporting" measures will be incorporated into the ECM Provider Capacity and ILOS Provider Capacity priorities in PY 1 (i.e. CY 2022). Quality outcome measures will be incorporated in PY 2 (i.e., CY 2023) and beyond.

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Performance Incentive Design Principles

1. Develop a clear incentive payment allocation methodology where all plans have an opportunity to participate equitably
2. Set ambitious, yet achievable measure targets
3. Ensure efficient and effective use of all performance incentive dollars
4. Drive significant investments in core priority areas up front
5. Minimize administrative complexity
6. Address variation in existing infrastructure and capacity between Whole Person Care (WPC) / Health Home Program (HHP) counties and non-WPC/HHP counties
7. Ensure use of incentive dollars does not overlap with other DHCS incentive programs or with services funded through the rates
8. Measure and report on the impact of incentive funds

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Incentive Payment Allocation Methodology

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Allocating Incentive Dollars to MCPs in Program Year 1

DHCS plans to set a cap on the maximum potential incentive dollars that can be earned by an MCP in each program year. Actual payments earned by an MCP would be based on achievement of "Gate" and "Ladder" Milestones.

"Gate" Milestone Linked to 50% of Available Dollars in PY1

- Consists of submission of "Gap Assessment and Gap-Filling Plan" measures outlining implementation approach to address gaps and needs.
- Completion of "Gate" requirements triggers upfront, incentive payment "advance" / interim payment.
- Advance / interim payment intended to be used to implement activities outlined in the Gap-Filling Plan.
- DHCS will recoup a portion of the advance from MCPs who fail to make a minimum level of effort to implement their Gap-Filling Plan.

"Ladder" Milestones Linked to 50% of Available Dollars in PY1

- Demonstrated performance against measure targets linked to achievement of "Gap-Filling Plan" targets.
- Achievement of "Ladder" measure targets result in subsequent incentive payments.

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Timing of PY1 Payments

DHCS proposes a bi-annual payment cycle to issue $600M in payments to MCPs in PY1 (CY 2022).

January 2022 Payment

- DHCS issues 50% of available dollars ($300 M)
- Tied to completion of “Gate” requirements
- “Gate” requirements to be completed and reported by MCPs in fall 2021

December 2022 Payment

- DHCS issues 50% of available dollars ($300 M)
- Tied to completion of second set of “Ladder” measures, which will be based on PY 1 priority areas
- “Ladder” measures to be submitted by MCPs in fall 2022, based on activity from January – June 2022

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DHCS Will Set Cap on *Maximum Potential* Incentive Dollars Each MCP Can Earn

DHCS plans to establish a three-step process to set the cap on the *maximum potential* amount of incentive dollars each MCP can earn. Incentive payments *actually earned* by MCPs will be determined by performance on measures.

- **Step 1.** Set maximum **potential** incentive amount that can be earned **across MCPs within a given county** based on total managed care enrollment or revenue
  - ***Adjustment:*** Increase potential payments in counties without WPC/HHP
- **Step 2.** Set maximum **potential** amount that can be earned **by each MCP within a given county** based on their managed care enrollment or revenue
  - ***Adjustment*:** Increase potential payments based on proportion of enrollees who are members of the ECM populations of focus
- **Step 3.** Set **potential** amount available to be earned **across priority areas** for PY1 (CY 2022) (see Slide 11 for detail on allocation by priority)
  - ***Priority areas*:** 1) Infrastructure development; 2) ECM capacity; 3) ILOS uptake and capacity

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Allocation of Dollars by Priority Area

MCPs will have some flexibility to propose the percentage of their cap that can be earned in each priority area based on a submission to DHCS as part of their Gap-Filling Plans. Final determinations will be made by DHCS.

- MCPs will propose the percentage of their cap that can be earned in each priority area based on the following methodology:
  - **70% of the cap must be allocated as follows:**
    - *Minimum of 20% tied to Delivery System Infrastructure measures*
    - *Minimum of 20% tied to ECM Provider capacity building measures* [2]
    - *Minimum of 30% tied to ILOS Provider capacity building and take-up measures* [1,2]
  - **Remaining 30% is allocated at the plans discretion to one or more areas**
    - MCPs who want to request more than the 30% allocated for discretionary use will need to provide their rationale to DHCS as soon as possible; DHCS may consider granting exceptions in very limited cases where the MCP's rationale is compelling
- **DHCS must ultimately approve the approach via review of Gap-Filling Plan**

[1] In CY 2022 (PY 1), MCPs are eligible to earn a "Gate" payment for ILOS if offering ILOS in January 2022 ***or*** *July 2022*

[2] Quality "pay for reporting" measures will be incorporated into the ECM Provider Capacity and ILOS Provider Capacity priorities

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Incentive Payment Priorities and Measure Domains

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Program Year 1 Priorities

DHCS focused initial PY 1 (i.e., CY 2022) funding priority areas* on capacity building, infrastructure, and ILOS take-up.

Delivery System Infrastructure	ECM Provider Capacity Building	ILOS Provider Capacity Building & MCP Take-Up
Fund core MCP, ECM and ILOS Provider HIT and data exchange infrastructure required for ECM and ILOS	*Fund ECM workforce, training, TA, workflow development, operational requirements and oversight*	*Fund ILOS training, TA, workflow development, operational requirements, take-up and oversight*

Physical and behavioral health integration between and among Providers and MCPs, health equity advancement, and health disparities reduction have been integrated into all three goal areas wherever feasible.

** Quality "pay for reporting" measures will be incorporated into the ECM Provider Capacity and ILOS Provider Capacity priorities in PY 1 (i.e. CY 2022). Quality outcome measures will be incorporated in PY 2 (i.e., CY 2023) and beyond.*

Measure Domains by Priority Area

PY 1 Priorities	Measure Domains
1. Delivery System Infrastructure	**1A.** Purchase or upgrade of ECM and ILOS IT systems and Provider capabilities including certified EHR technology, care management document systems, closed-loop referral, billing systems/services, and onboarding/enhancements to health information exchange capabilities
2. ECM Provider Capacity Building	**2A.** Building/expanding ECM Provider networks and compliance and oversight capabilities to ensure populations of focus within a county can be effectively served
	2B. Hiring and training ECM care managers, care coordinators, community health workers, and supervisors to ensure core competencies to support ECM requirements
3. ILOS Provider Capacity Building and ILOS Take-Up	**3A.** Offering ILOS, expanding reach of ILOS offered
	3B. Building/expanding ILOS Provider networks and compliance and oversight capabilities of ILOS to ensure populations within a county can be effectively served
	3C. Hiring and training ILOS Provider support staff, workflow redesign, and training
4. Quality	**4A.** Reporting of baseline data ("Pay for Reporting" only in Program Year 1) to inform quality outcome measures to be collected in future program years.

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High Performance Pool

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Distribution of High Performance Pool

DHCS plans to create a high-performance pool for unearned "Gate" and "Ladder" dollars. MCPs who qualify for the high performance pool and meet additional targets can earn incentive dollars above and beyond those dollars tied to "Gate" and "Ladder" measures.

- If a plan does earn the "Gate" advance/interim payment or does not meet sufficient "Ladder" measures to earn up to their cap (i.e., does not earn their maximum potential for incentive dollars), DHCS will reallocate the unearned dollars to a high performance pool that can be earned by other MCPs.
- An MCP's unearned "Ladder" measure incentive dollars would be eligible to be earned by other MCPs statewide who meet minimum standards and high performance pool targets.

High Performance Pool Eligibility

MCPs must meet minimum requirements to be eligible to earn high performance pool dollars; actual allocation of high performance pool dollars to be determined based on performance on measures and available funds, as evaluated during PY1 reporting periods.

High Performance Pool Minimum Requirements

- Meet all requirements to earn "Gate" interim payment/advance, and;
- Offer at least one ILOS, and;
- Perform in the top Xth percentage of MCPs for ladder measures across domains; percentile to be set by DHCS based on dollars available for high performance pool

High Performance Pool Measures

- Meet "stretch goal" targets for the "Ladder" measures already required across priority areas

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Consequences for Failure to Meet Requirements of “Payment Advance”

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Consequences for Failure to Meet Requirements of "Payment Advance"

Completion of Gap/Need Assessment and Gap-Filling Plan triggers an upfront, "Gate" payment "advance"/interim payment. MCPs must *implement* activities outlined in the Gap-Filling Plan to fully meet the "Gate" measure. DHCS reserves the right to recoup a portion of the advance from MCPs who fail to make a minimum level of effort to implement their Gap-Filling Plan.

- In PY1, DHCS will evaluate MCPs based on their results and achievement of process measures outlined in the Gap-Filling Plan.
- MCPs that fail to demonstrate a minimum level of effort, as determined by DHCS, must work with DHCS on a corrective action plan aimed at improving results and performance on the process measures.
- MCPs that fail to follow the corrective action plan and meet the minimum level of effort must return a portion of the "Gate" payment advance, to be determined by DHCS.

Thank you

Please visit the DHCS ECM & ILOS Website for more information and access to this deck as well as the Incentive Payment measure list: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx

Please send questions to CalAIMECMILOS@dhcs.ca.gov

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Approval of Program Year 1 CalAIM Performance Incentive Payment Methodology for AltaMed Health Services Corporation

Contact

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

Recommended Actions

1. Approve Program Year (PY) 1 CalAIM Performance Incentive Payment Methodology for the Medi-Cal line of business for AltaMed Health Services Corporation that defines measures and allocations effective January 1, 2022, through December 31, 2022;
2. Authorize the allocation and distribution of CalAIM Program Incentive Dollars for PY 1 to CalOptima and delegated health networks in accordance with the recommended methodology in an aggregate amount for all health networks not to exceed $45 million; and
3. Authorize funding for and the distribution of incentive payments prior to CalOptima's receipt of CalAIM Program Incentive Dollars from the State of California.

Background

In preparation for the start of CalAIM's Enhanced Care Management (ECM) and In Lieu of Services (ILOS) programs on January 1, 2022, the California Department of Health Care Services (DHCS) will provide managed care plans with performance incentives to promote provider participation and capacity building. The state budget includes funding for incentive payments beginning on January 1, 2022 and ending in Fiscal Year (FY) 2024-25. Specifically, the state budget includes an allocation of $300 million for plan incentives from January 1, 2022, through June 30, 2022; $600 million for FY 2022-23; and $600 million for FY 2023-24. The incentive funding will phase out in FY 2024-25.

The initial PY 1 funding priority areas include:

- Delivery System Infrastructure;
- ECM Provider Capacity Building;
- ILOS Provider Capacity Building and managed care plan take-up; and
- Quality "Pay for Reporting" measures (which will be incorporated in the ECM provider capacity and ILOS provider capacity building priorities.

For PY 1, the state budget includes a $600 million allocation. DHCS plans to set a cap on the potential incentive dollars managed care plans may earn each program year and will provide a breakdown of the dollars across each priority area. These amounts will be based on total managed care enrollment and revenue. The actual payments earned by a plan in PY 1 will be based on the achievement of DHCS-specified "Gate" and "Ladder" milestones.

Discussion

In order to properly assess the delivery system infrastructure and ECM and ILOS provider capacity in Orange County, CalOptima is required to submit a "Gap Assessment and Gap Filling Plan" in Fall 2021. This plan will report to DHCS on baseline data and outlines CalOptima's implementation plan to

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address the identified gaps and needs. Attachment 2 provides information on DHCS' proposed milestones and measures.

DHCS Funding

On September 28, 2021, DHCS informed CalOptima that the amount of potential incentive dollars for PY 1 is approximately $45.0 million. This funding level accounts for the already existing Whole Person Care (WPC) and Health Homes Program (HHP) infrastructure in Orange County. DHCS plans to divide the timing of the PY 1 payments and the requirements for earning such payments into two (2); the first in January 2022 and the second in December 2022.

Payment 1: Anticipated January 2022

CalOptima management anticipates receiving half of the potential incentive amount or approximately $22.5 million in January 2022. DHCS intends managed care plans to use prepaid dollars to implement the activities outlined in the Gap Filling Plan. As such, CalOptima will need to complete the specified "Gate" requirements and report back to DHCS in Fall 2021. If CalOptima fails to make a minimum level of effort to implement their Gate-Filling Plan, DHCS reserves the right to recoup a portion of the prepaid funding.

Payment 2: December 2022

CalOptima management anticipates receiving the second half of the potential incentive amount or $22.5 million in December 2022. The state will measure CalOptima's performance against targets linked to the achievement of measures in the Gap Filling Plan (i.e., "Ladder" measures). CalOptima will need to report these measures to DHCS in Fall 2022 based on activities completed from January through June 2022.

CalOptima, in its capacity as a managed care plan, shall retain a portion of the incentive funding for retained ILOS risk. Staff estimates PY 1 funding of up to $14.5 million for this purpose. Up to $30.5 million in incentive funding will be distributed to health networks.

Health Networks

CalOptima Direct Networks (CCN/COD)

CCN/COD will be subject to the same allocation criteria as those described below.

Delegated Health Networks (HMO, PHC, SRG)

To ensure adequate revenue to support provider participation and capacity building, CalOptima will distribute incentive dollars consistent with DHCS guidance, based on the assumed delegated risk under CalAIM and contingent on the maximum potential incentive dollars as communicated by DHCS. CalOptima will employ the following to make incentive payments to delegated health networks.

Payment 1: A health network must be in good standing with CalOptima at the time of disbursement. Eligible health networks shall receive as prefunding, an allocation of the amount of incentive dollars available. This allocation will take into account the anticipated delivery system infrastructure and ECM and ILOS provider capacity, as well as the level of delegated responsibility.

- CalOptima will distribute each health network's allocation upon completion of a final calculation. The allocation will include a fixed component of $250,000 per health network and variable components based on the health network's projected proportion by "populations of focus," as defined by DHCS; and
- CalOptima, at its sole discretion, may make annual or more frequent payments to health networks.

A health network shall submit a completed attestation form, signed by its Chief Executive Officer or Chief Financial Officer. CalOptima will provide a form that each health network can use to attest to the level of spending by PY 1 funding priority area. The health network's allocation of incentive dollars is as follows:

- 30% to Delivery System Infrastructure;
- 30% to ECM Provider Capacity Building;
- 15% to ILOS Provider Capacity Building; and
- 25% to health network discretion to one or more of the above priority areas.

Each health network shall participate in data collection, reporting activities and data submission to CalOptima, including measures for the Gap Assessment and Gap-Filling Plan and other subsequent data reporting requested by CalOptima. As of this writing, DHCS continues to develop and finalize guidance for the implementation of ECM and ILOS, including policy guidance for incentive payments and data sharing. Staff will return to the Board with additional information on measures and health network data sharing requirements pursuant to DHCS final guidance.

Payment 2: To qualify for funding, a health network must be in good standing with CalOptima at the time of disbursement.

- CalOptima will distribute each health network's allocation upon completion of a final calculation. The allocation will be based on demonstrated performance against measure targets and the projected health network proportion by "populations of focus," as defined by DHCS; and
- CalOptima, at its sole discretion, may make annual or more frequent payments to health networks.

Each health network shall participate in data collection, reporting activities and data submission to CalOptima, including measures for the "Ladder" measures and other subsequent data reporting requested by CalOptima.

In the event DHCS recoups any portion of the incentive funding due to a lack of effort to implement or to demonstrate performance against measure targets, CalOptima reserves the right to make subsequent recoupments from health networks. A health network shall participate in taking corrective actions and submitting updates to CalOptima on process measures identified by DHCS through a corrective action plan to CalOptima.

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Fiscal Impact

The fiscal impact of the PY 1 CalAIM performance incentive for the Medi-Cal line of business for January 1, 2022, through December 31, 2022, is projected to be budget neutral to CalOptima. The aggregate amount payable to all CalOptima and delegated health networks is not anticipated to exceed $45.0 million for PY 1. Staff anticipates any cash expended for the provider incentive payments will be replenished when CalAIM performance incentive dollars are received from DHCS.

Rationale for Recommendation

The recommended actions will enable CalOptima to support provider participation and capacity building in preparation of CalAIM ECM and ILOS programs.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. DHCS Proposed Milestones and Measures for CalAIM Incentive Payments (Draft for stakeholder feedback dated August 30, 2021)
3. CalAIM Performance Incentives (Draft for stakeholder feedback dated June 30, 2021)

/s/ Richard Sanchez — *10/28/2021*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima Medi-Cal Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

DHCS

Proposed Milestones and Measures for CalAIM Incentive Payments
DRAFT - August 30, 2021

Priority	Percentage of Dollars (i.e., Max Cap) Allocated to Priority Area	Points Needed to Earn Max Payment 1	Points Needed to Earn Max Payment 2
1. Delivery System Infrastructure	Minimum 20%	200	200
2. ECM Provider Capacity Building	Minimum of 20%	200	200
3. ILOS Provider Capacity Building and ILOS Take-Up	Minimum of 30%	300	300
4. Quality	Optional measures with values allocated to either ECM or ILOS	N/A	To be allocated to ECM or ILOS based on measure
Total Points		700	700
MCP Discretion to Allocate to One or More Priority Areas	Up to 30% of Max Cap to be added to one or more of the above priority areas based on discretion of the plan, as reported in the Gap-Filling Plan template		

MCPs are required to submit information pertaining to the measures noted as mandatory, and can select among additional optional measures, to earn up to their full cap. DHCS will evaluate the MCP submissions and award payments proportional to the number of points earned per measure (as specified in the Reporting Template).MCPs are permitted and encouraged to work closely with providers and other stakeholders on these measures.

High Performance Pool: MCPs will receive payments from the high performance pool based on their performance against their individualized targets for each of their quantitative requirements reported as part of the submission for Payment 2. MCPs must meet minimum requirements to be eligible to earn high performance pool dollars, including:
-- Report on all mandatory requirements for the Gap/Need Assessment and Gap Filling Plan;
-- Offer at least three ILOS, and;
-- Demonstrate a minimum level of effort to implement their Gap-Filling Plan (i.e., are not placed on a corrective action plan).

Priority	Payment 1 Measures	Target for Payment 1 Measures	Optional / Mandatory for Payment 1	Weighting for Payment 1 Measures (Points Out of 700 Across Domains)	Payment 2 Measures	Target for Payment 2 Measure	Optional / Mandatory for Payment 2 Measures	Weighting for Payment 2 Measures (Points Out of 700 Across Domains)	Measure to Determine if Payment 1 is Fully Earned (i.e., Not Subject to Recoupment)?
1. Delivery System Infrastructure	Number and percent of contracted ECM Providers capable of electronically exchanging care plan information and clinical documents with other care team members	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted ECM Providers capable of electronically exchanging care plan information and clinical documents with other care team members	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Number and percent of contracted ECM Providers with access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted ECM Providers with access to certified EHR technology or a care management documentation systems able to generate and manage a patient care plan	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Number and percent of contracted ECM and ILOS Providers who are capable of submitting a claim or invoice to an MCP, or have access to a system or service that can process and send a claim or invoice to an MCP with information necessary for the MCP to submit a compliant encounter to DHCS	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted ECM and ILOS providers capable of submitting a claim or invoice to a MCP, or have access to a system or service that can process and send a claim or invoice to a MCP with information necessary for the MCP to submit a compliant encounter to DHCS	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Number and percent of contracted ILOS Providers for those ILOS offered by the MCP starting January 1, 2022 or July 1, 2022 who have access to closed-loop referral systems	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted ILOS Providers for those ILOS offered by the MCP starting January 1, 2022 or July 1, 2022 with access to closed-loop referral systems	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Number and percent of contracted behavioral health providers able to electronically exchange care plan information and clinical documents with other care team members	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted behavioral health providers able to electronically exchange care plan information and clinical documents with other care team members	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Submission of a narrative or joint MOU describing how the MCP will collaborate with other MCPs in the county to enhance and develop needed ECM/ILOS infrastructure, including certified EHR technology, care management document systems, closed-loop referral, billing systems/services, and onboarding/enhancements to health information exchange capabilities and submission of documentation demonstrating good faith efforts to begin this collaboration in the form of letters with MCPs in county, emails demonstrating progress, meeting meetings, or other documentation. If only one MCP is operating in the county, the MCP must submit a narrative describing how they will leverage and expand existing WPC capacity and support ongoing ECM and ILOS capacity building approaches	See reporting template for evaluation criteria for MOU	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Narrative describing how the MCP successfully collaborated with other MCPs in the county to enhance and develop needed ECM/ILOS infrastructure, including certified EHR technology, care management document systems, closed-loop referral, billing systems/services, and onboarding/enhancements to health information exchange capabilities	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Submission of a narrative Gap-Filling plan describing how MCPs will identify underserved populations and the ECM providers they are assigned to, and enhance those ECM Providers' capabilities to: (1) Electronically exchange care plan information and clinical documents with other care team members (2) Have access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan. (3) Submit a claim or invoice to an MCP, or have access to a system or service that can process and send a claim or invoice to an MCP with information necessary for the MCP to submit a compliant encounter to DHCS MCPs should also describe any plans to build physical plant infrastructure (e.g., sobering centers) to support the launch of ECM and ILOS. Gap-Filling Plan narrative should include approaches for collaborating with, Social Services, County Behavioral Health, and County/Local Public Health Agencies within the county to achieve the above activities, and should describe how health plans will leverage existing WPC infrastructure, including how they will track the ongoing viability of WPC infrastructure and improve data integration across behavioral health and physical health providers	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	80	Submission of a narrative demonstrating progress against Gap-Filling Plan, including identification of underserved populations and the ECM providers they are assigned to, and enhancements that have been made to those ECM Providers' capabilities to: (1) Electronically exchange care plan information and clinical documents with other care team members (2) Have access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan. (3) Submit a claim or invoice to an MCP, or have access to a system or service that can process and send a claim or invoice to an MCP with information necessary for the MCP to submit a compliant encounter to DHCS MCPs should also describe any progress to build physical plant infrastructure (e.g., sobering centers) to support the launch of ECM and ILOS. Narrative should outline progress on collaborations with Social Services, County Behavioral Health, and Counties/Local Public Health Agencies within the county to achieve the above activities, and should describe how health plans have leveraged existing WPC infrastructure and improved data integration across behavioral health and physical health providers.	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	80	**Yes**
2. ECM Provider Capacity Building	Number of contracted ECM Providers	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	20	Number of contracted ECM Providers	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	20	No
2. ECM Provider Capacity Building	Number of members identified as eligible to transition from HHP/WPC to ECM	N/A - Pay for Reporting	**Optional,** Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 points	Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 Points	Number of Members receiving ECM	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	10	No
2. ECM Provider Capacity Building	Number of Members across Program Year 1 Populations of Focus expected to require ECM. Break out of Members across Program Year 1 Populations of Focus expected to require ECM by race, ethnicity, and primary language.	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	10	Number of Members across Program Year 1 Populations of Focus receiving ECM. Break out of Members across Program Year 1 Populations of Focus receiving ECM by race, ethnicity, and primary language.	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	10	No
2. ECM Provider Capacity Building	Submission of a narrative or joint MOU describing how the MCP will collaborate with other MCPs in the county to support expansion of ECM Provider capacity, including leveraging and expanding existing WPC capacity and building/expanding ECM Provider networks and compliance and oversight capabilities. MCP should also submit documentation demonstrating good faith efforts to begin this collaboration in the form of letters with MCPs in county, emails demonstrating progress, meeting meetings, or other documentation. If only one MCP is operating in the county, the MCP must submit a narrative describing how they will leverage and expand existing WPC capacity and support ongoing ECM capacity building approaches	See reporting template for evaluation criteria for MOU	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	10	Narrative describing how the MCP successfully collaborated with other MCPs in the county to support ECM Provider capacity expansion, and leverage existing WPC capacity. If only one MCP is operating in the county, the narrative must describe how they successfully leveraged and expanded existing WPC capacity to support ECM capacity building	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	20	No
2. ECM Provider Capacity Building	Narrative summary that outlines landscape of Providers, faith-based groups, and community based organizations in the county and submission of a narrative plan to develop an MOU or other agreements with a subset of Providers, faith-based groups, county agencies and community based organizations in the county to develop strategies for closing health disparities experienced by Populations of Focus, including agreement to meet at least quarterly to advance strategy	See reporting template for evaluation criteria for narrative summary	**Optional,** Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 points	Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 Points	Submission of MOU or other collaborative agreement, associated agenda and meeting notes and narrative description of progress against narrative plan submitted as part of Payment 1 measure for the strategic partnership with the MCP, Providers, faith-based groups, county agencies and community based organizations to a develop strategy for closing health disparities experienced by Populations of Focus	See reporting template for evaluation criteria for MOU	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building	Narrative summary that outlines landscape of Tribes and Tribal providers used by members in the county and submission of a narrative plan to develop an MOU to establish a strategic partnership with Tribes and Tribal providers used by members in county to develop Provider capacity and provision of ECM services for members of Tribes	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 1 Tied to ECM Provider Capacity, except for Plans in Counties without recognized Tribes	30	Submission of MOU or other collaborative agreement, associated agenda and meeting notes and narrative description of progress against narrative plan submitted as part of Payment 1 measure, to demonstrate progress made to work with Tribes and Tribal providers used by members in county on Provider capacity and provision of ECM services for members of Tribes in county	See reporting template for evaluation criteria for MOU	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	20	No

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Priority	Payment 1 Measures	Target for Payment 1 Measures	Optional / Mandatory for Payment 1	Weighting for Payment 1 Measures (Points Out of 700 Across Domains)	Payment 2 Measures	Target for Payment 2 Measure	Optional / Mandatory for Payment 2 Measures	Weighting for Payment 2 Measures (Points Out of 700 Across Domains)	Measure to Determine if Payment 1 is Fully Earned (i.e., Not Subject to Recoupment)?
2. ECM Provider Capacity Building	Submission of narrative plan describing how the managed care plan will improve outreach to and engagement with the following Population of Focus: "*people experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless with complex health and/or behavioral health conditions,* " with a focus on Black/African American and other racial and ethnic groups who are disproportionately experiencing homelessness	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	30	Baseline data for individuals who are Black/African American and from other racial and ethnic groups who are disproportionately experiencing homelessness and who meet the Population of Focus definition: "*people experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless with complex health and/or behavioral health conditions* " **and narrative summary** of progress the MCP made to improve outreach to and engagement with individuals who are Black/African American and other racial and ethnic groups who are disproportionately experiencing homelessness	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	20	No
2. ECM Provider Capacity Building	Submission of narrative plan describing how the managed care plan will improve outreach to and engagement with the following Population of Focus: "individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of sevices to the community," with a focus on Black/African American and other racial and ethnic groups who are disproportionately experiencing transitions from incarceration settings in the county	See reporting template for evaluation criteria for narrative summary	**Optional,** Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 points	Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 Points	Baseline data for individuals who are Black/African American and from other racial and ethnic groups who disproportionately meet the Population of Focus definition: "*individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community* " who have been successfully outreached to and engaged by an ECM Provider and **narrative summary** of progress the MCP made to improve outreach to and engagement with Black/African American and other racial and ethnic groups who are disproportionately experiencing transitions from incarceration settings	N/A - Pay for Reporting	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building	Reporting on racial and ethnic demographics of ECM Providers for each Program Year 1 Populations of Focus relative to the racial and ethnic demographics of the Members in each Program Year 1 Populations of Focus	N/A - Pay for Reporting	**Optional,** Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 points	Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 Points	Reporting on racial and ethnic demographics of ECM Providers for each Program Year 1 Populations of Focus relative to the racial and ethnic demographics of the beneficiaries in the Program Year 1 Populations of Focus	N/A - Pay for Reporting	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building					Hired full time Health Equity Officer by July 1, 2022 who has the necessary qualifications or training at the time of hire or within 1 year of hire to meet the requirements of the position, as outlined in the MCP Procurement	N/A - Pay for Reporting	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building					Rates of sharing ECM assessment and care plan information across physical and behavioral health care teams	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	10	No
2. ECM Provider Capacity Building	Submission of a narrative Gap-Filling plan describing: (1) How the MCP will address identified gaps in ECM Provider capacity for Program Year 1 Populations of Focus (2) Identified ECM workforce, training, TA needs in county, including specific cultural competency needs by county (3)Plan for ECM Provider workforce recruiting and hiring of necessary staff to build capacity (4) Approach for MCP to develop and administer an MCP training and TA program for ECM Providers (5) Strategy to ensure ECM Providers are successfully engaging with hard to reach Populations of Focus, including homeless and justice involved populations, among others Gap-Filling Plan narrative should include approach for collaborating with Social Service, County Behavioral Health, County/Local Public Health Agencies, Tribes and Tribal providers (except for Plans in Counties without recognized Tribes), community based organizations and ECM Providers to achieve the above activities, improve outreach to and engagement with hard to reach individuals within each Populations of Focus and reduce underlying health disparities	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	70	Submission of a narrative describing progress against Gap-Filling plan, including: (1) Progress in increasing ECM Provider capacity and MCP oversight capacity (1) Progress in addressing ECM workforce, training, TA needs in county, including specific cultural competency needs by county (2) Progress in supporting ECM Provider workforce recruiting and hiring of necessary staff to build capacity (3) Progress in developing and administering a MCP training and TA program for ECM Providers (4) Progress in successfully engaging with hard to reach Populations of Focus, including homeless and justice involved populations, among others Narrative should outline progress and results from collaborations with County Social Service, Behavioral Health, County/Local Public Health Agencies, Tribes and Tribal providers (except for Plans in Counties without recognized Tribes), community based organizations and ECM Providers to achieve the above activities, improve outreach to and engagement with hard to reach individuals within each Populations of Focus and reduce underlying health disparities.	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	60	**Yes**
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Plan All-Cause Readmissions (PCR)** For beneficiaries ages 18 to 64 who are in the ECM populations of focus, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: • Count of Index Hospital Stays (IHS) • Count of Observed 30-Day Readmissions • Count of Expected 30-Day Readmissions	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Ambulatory Care—Emergency Department Visits (AMB-ED)** Rate of emergency department (ED) visits per 1,000 beneficiary months for beneficiaries who are in the ECM populations of focus	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Depression Screening and Follow-Up for Adolescents and Adults (DSF)** The percentage of beneficiaries 12 years of age and older who are in the ECM populations of focus and who were screened for clinical depression using a standardized tool and, if screened positive, who received follow-up care.	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)** The percentage of members 12 years of age and older with a diagnosis of depression, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Follow-Up After Emergency Department Visit for Mental Illness (FUM)** Percentage of emergency department (ED) visits for beneficiaries age 18 and older who are in the ECM populations of focus and who have a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)** Percentage of emergency department (ED) visits for beneficiaries age 18 and older who are in the ECM populations of focus and have a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: • Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) • Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Controlling High Blood Pressure (CBP)** Percentage of beneficiaries ages 18 to 85 who are in the ECM populations of focus and who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)** Percentage of children ages 1 to 17 who are in the ECM populations of focus and who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: • Percentage of children and adolescents on antipsychotics who received blood glucose testing • Percentage of children and adolescents on antipsychotics who received cholesterol testing • Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
3. ILOS Provider Capacity Building and ILOS Take-Up	Number of contracted ILOS Providers	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up	20	Number of contracted ILOS Providers	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	20	No

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Priority	Payment 1 Measures	Target for Payment 1 Measures	Optional / Mandatory for Payment 1	Weighting for Payment 1 Measures (Points Out of 700 Across Domains)	Payment 2 Measures	Target for Payment 2 Measure	Optional / Mandatory for Payment 2 Measures	Weighting for Payment 2 Measures (Points Out of 700 Across Domains)	Measure to Determine if Payment 1 is Fully Earned (i.e., Not Subject to Recoupment)?
3. ILOS Provider Capacity Building and ILOS Take-Up	Number of members identified as eligible to transition from HHP/WPC to ILOS	N/A - Pay for Reporting	**Optional,** Report on One Optional Payment 1 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 50 points	Report on One Optional Payment 1 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 50 Points	Number of Members receiving ILOS	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	20	No
3. ILOS Provider Capacity Building and ILOS Take-Up	Offer ILOS housing suite: housing transition navigation, housing deposits, housing tenancy and sustaining services, short-term post-hospitalization housing, day habilitation programs, and medical respite starting in January 2022 or July 2022	N/A - MCPs must offer the full ILOS housing suite to earn incentive dollars tied to this measure	**Optional,** Report on One Optional Payment 1 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 50 points	Report on One Optional Payment 1 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 50 Points					
3. ILOS Provider Capacity Building and ILOS Take-Up	Number of ILOS offered county-wide by the MCP starting January 2022 or July 2022 *If the ILOS Provider network/capacity will not reasonably allow for county-wide provision of ILOS to all eligible Members in the county at the time of implementation, please provide additional information in the Gap-Filling Plan. DHCS will review the information provided to determine if the county-wide provision of a given ILOS is not a reasonable expectation and work with the MCP to assess if a given ILOS not offered county-wide will count toward this measure.*	Evaluated based on number of ILOS offered county-wide: 1-4 = 60 points 5-7 = 70 point 8+ = 80 points	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up	Points awarded based on number of ILOS offered: 1-4 = 60 points 5-7 = 70 point 8+ = 80 points					
3. ILOS Provider Capacity Building and ILOS Take-Up	Narrative summary that outlines landscape of Tribes and Tribal providers used by members in the county and submission of a narrative plan to develop an MOU to establish a strategic partnership with Tribes and Tribal providers used by members in county to develop Provider capacity and provision of provision of ILOS for members of Tribes in county	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up, except for Plans in Counties without recognized Tribes	20	Submission of MOU or other collaborative agreement, associated agenda and meeting notes and narrative description of progress against narrative plan submitted as part of Payment 1 measure, to demonstrate progress made to work with Tribes and Tribal providers used by members in county on Provider capacity and provision of ILOS for members of Tribes and Tribal providers used by members in county	See reporting template for evaluation criteria for MOU	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	20	No
3. ILOS Provider Capacity Building and ILOS Take-Up					Percent of enrollees receiving ILOS by race, ethnicity, and primary language, relative to the demographics in the underlying enrollee population	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	50	No
3. ILOS Provider Capacity Building and ILOS Take-Up	Submission of a narrative or joint MOU describing how the MCP will collaborate with other MCPs in the county to leverage and expand existing WPC capacity and support ongoing ILOS capacity building approaches. MCP should also submit documentation demonstrating good faith efforts to begin this collaboration in the form of letters with MCPs in county, emails demonstrating progress, meeting meetings, or other documentation. If only one MCP is operating in the county, the MCP must submit a narrative describing how they will leverage and expand existing WPC capacity and support ongoing ILOS capacity building approaches	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up	50	Narrative describing how the MCP successfully collaborated with other MCPs in the county to leverage and expand existing WPC capacity and support ongoing ILOS capacity building approaches. If only one MCP is operating in the county, the MCP must submit a narrative describing how they successfully leveraged and expanded existing WPC capacity to support ongoing ILOS capacity building approaches.	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	50	No
3. ILOS Provider Capacity Building and ILOS Take-Up	Submission of a narrative Gap-Filling plan describing: (1) Identified gaps or limitations in ILOS coverage within county (2) Plan to increase number and/or reach of ILOS offered in January 2022 or July 2022 (3) Identified ILOS Provider capacity and MCP oversight capability gaps and plan to address gaps (4) Identified ILOS workforce, training, TA needs in region / county, including specific cultural competency needs by region/county (5) Plan to develop and administer a training and TA program for ILOS Providers (6) Plan to establish programs to support ILOS workforce recruiting and hiring, including incentives for ILOS Providers to hire necessary staff Gap-Filling Plan narrative should include approach for collaborating with Social Service, County Behavioral Health, County/Local Public Health Agencies, and ILOS Providers to achieve the above activities, improve outreach to and engagement with hard to reach individuals and reduce underlying health disparities.	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up	80	Submission of a narrative demonstrating progress against Gap-Filling plan, including: (1) Reduced gaps or limitations in ILOS coverage across county (2) Increased number and/or reach of ILOS offered in January 2022 or July 2022 (3) Reduction in ILOS Provider capacity and MCP oversight capability gaps (4) Resolution of ILOS workforce, training, TA needs in region / county, including specific cultural competency needs by region/county (5) Successfully administered training and TA program for ILOS Providers (6) Demonstrated support for ILOS workforce recruiting and hiring Narrative should outline progress and results from collaborations with County Social Service, Behavioral Health, County/Local Public Health Agencies, and ILOS Providers to achieve the above activities, improve outreach to and engagement with hard to reach individuals, and reduce underlying health disparities.	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	120	Yes
3. ILOS Provider Capacity Building and ILOS Take-Up *Quality Measure*					**Submission of baseline data for Asthma Medication Ratio** The percentage of beneficiaries ages 5 to 64 who are receiving ILOS, 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	N/A - Pay for Reporting in CY 2022	**Optional,** Report on One Optional Payment 2 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 20 points	Report on One Optional Payment 2 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 20 Points	No

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CalAIM Performance Incentives

DRAFT for Stakeholder Feedback

June 30, 2021

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- Overview of Incentive Payment Approach
- Allocation Methodology and Timing
- Payment Priorities and Measure Domains
- High Performance Pool
- Consequences for Failure to Meet Requirements of "Gate Payment Advance"
- Questions

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Overview

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CalAIM Performance Incentives Overview

CalAIM's Enhanced Care Management (ECM) and In Lieu Of Services (ILOS) programs will launch in January 2022, requiring significant new investments in care management capabilities, ILOS infrastructure, information technology (IT) and data exchange, and workforce capacity at both the managed care plan (MCP) and provider levels.

- Incentive payments will be a critical component of CalAIM to promote MCP and provider participation in, and capacity building for, ECM and ILOS.
- The Governor's budget allocated $300 million for plan incentives from January to June 2022, $600 million from July 2022 to June 2023, and $600 million from July 2023 to June 2024. Incentive funding will phase out in FY 2024-25.
- DHCS has designed the proposed incentive payment approach with input from stakeholders with the goal of issuing initial payments to MCPs beginning in January 2022 for the achievement of defined milestones.

Performance Incentive Goals

- **Build appropriate and sustainable ECM and ILOS capacity**
- **Drive MCP investment in necessary delivery system infrastructure**
- **Incentivize MCP take-up of ILOS**
- **Bridge current silos across physical and behavioral health delivery**
- **Reduce health disparities and promote health equity**
- **Achieve improvements in quality performance**

Infrastructure development, ECM and ILOS Provider capacity building, and ILOS take-up are priority areas for Program Year (PY)1 (i.e., Calendar Year (CY) 2022). DHCS will incorporate behavioral and physical health integration and health disparities reduction measures within those priority areas.

Quality "pay for reporting" measures will be incorporated into the ECM Provider Capacity and ILOS Provider Capacity priorities in PY 1 (i.e. CY 2022). Quality outcome measures will be incorporated in PY 2 (i.e., CY 2023) and beyond.

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Performance Incentive Design Principles

1. Develop a clear incentive payment allocation methodology where all plans have an opportunity to participate equitably
2. Set ambitious, yet achievable measure targets
3. Ensure efficient and effective use of all performance incentive dollars
4. Drive significant investments in core priority areas up front
5. Minimize administrative complexity
6. Address variation in existing infrastructure and capacity between Whole Person Care (WPC) / Health Home Program (HHP) counties and non-WPC/HHP counties
7. Ensure use of incentive dollars does not overlap with other DHCS incentive programs or with services funded through the rates
8. Measure and report on the impact of incentive funds

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Incentive Payment Allocation Methodology

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Allocating Incentive Dollars to MCPs in Program Year 1

DHCS plans to set a cap on the maximum potential incentive dollars that can be earned by an MCP in each program year. Actual payments earned by an MCP would be based on achievement of "Gate" and "Ladder" Milestones.

"Gate" Milestone Linked to 50% of Available Dollars in PY1

- Consists of submission of "Gap Assessment and Gap-Filling Plan" measures outlining implementation approach to address gaps and needs.
- Completion of "Gate" requirements triggers upfront, incentive payment "advance" / interim payment.
- Advance / interim payment intended to be used to implement activities outlined in the Gap-Filling Plan.
- DHCS will recoup a portion of the advance from MCPs who fail to make a minimum level of effort to implement their Gap-Filling Plan.

"Ladder" Milestones Linked to 50% of Available Dollars in PY1

- Demonstrated performance against measure targets linked to achievement of "Gap-Filling Plan" targets.
- Achievement of "Ladder" measure targets result in subsequent incentive payments.

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Timing of PY1 Payments

DHCS proposes a bi-annual payment cycle to issue $600M in payments to MCPs in PY1 (CY 2022).

January 2022 Payment

- DHCS issues 50% of available dollars ($300 M)
- Tied to completion of “Gate” requirements
- “Gate” requirements to be completed and reported by MCPs in fall 2021

December 2022 Payment

- DHCS issues 50% of available dollars ($300 M)
- Tied to completion of second set of “Ladder” measures, which will be based on PY 1 priority areas
- “Ladder” measures to be submitted by MCPs in fall 2022, based on activity from January – June 2022

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DHCS Will Set Cap on *Maximum Potential* Incentive Dollars Each MCP Can Earn

DHCS plans to establish a three-step process to set the cap on the *maximum potential* amount of incentive dollars each MCP can earn. Incentive payments *actually earned* by MCPs will be determined by performance on measures.

- **Step 1.** Set maximum **potential** incentive amount that can be earned **across MCPs within a given county** based on total managed care enrollment or revenue
  - ***Adjustment:*** Increase potential payments in counties without WPC/HHP
- **Step 2.** Set maximum **potential** amount that can be earned **by each MCP within a given county** based on their managed care enrollment or revenue
  - ***Adjustment*:** Increase potential payments based on proportion of enrollees who are members of the ECM populations of focus
- **Step 3.** Set **potential** amount available to be earned **across priority areas** for PY1 (CY 2022) (see Slide 11 for detail on allocation by priority)
  - ***Priority areas*:** 1) Infrastructure development; 2) ECM capacity; 3) ILOS uptake and capacity

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Allocation of Dollars by Priority Area

MCPs will have some flexibility to propose the percentage of their cap that can be earned in each priority area based on a submission to DHCS as part of their Gap-Filling Plans. Final determinations will be made by DHCS.

- MCPs will propose the percentage of their cap that can be earned in each priority area based on the following methodology:
  - **70% of the cap must be allocated as follows:**
    - *Minimum of 20% tied to Delivery System Infrastructure measures*
    - *Minimum of 20% tied to ECM Provider capacity building measures* [2]
    - *Minimum of 30% tied to ILOS Provider capacity building and take-up measures* [1,2]
  - **Remaining 30% is allocated at the plans discretion to one or more areas**
    - MCPs who want to request more than the 30% allocated for discretionary use will need to provide their rationale to DHCS as soon as possible; DHCS may consider granting exceptions in very limited cases where the MCP's rationale is compelling
- **DHCS must ultimately approve the approach via review of Gap-Filling Plan**

[1] In CY 2022 (PY 1), MCPs are eligible to earn a "Gate" payment for ILOS if offering ILOS in January 2022 ***or*** *July 2022*

[2] Quality "pay for reporting" measures will be incorporated into the ECM Provider Capacity and ILOS Provider Capacity priorities

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Incentive Payment Priorities and Measure Domains

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Program Year 1 Priorities

DHCS focused initial PY 1 (i.e., CY 2022) funding priority areas* on capacity building, infrastructure, and ILOS take-up.

Delivery System Infrastructure	ECM Provider Capacity Building	ILOS Provider Capacity Building & MCP Take-Up
Fund core MCP, ECM and ILOS Provider HIT and data exchange infrastructure required for ECM and ILOS	*Fund ECM workforce, training, TA, workflow development, operational requirements and oversight*	*Fund ILOS training, TA, workflow development, operational requirements, take-up and oversight*

Physical and behavioral health integration between and among Providers and MCPs, health equity advancement, and health disparities reduction have been integrated into all three goal areas wherever feasible.

** Quality "pay for reporting" measures will be incorporated into the ECM Provider Capacity and ILOS Provider Capacity priorities in PY 1 (i.e. CY 2022). Quality outcome measures will be incorporated in PY 2 (i.e., CY 2023) and beyond.*

Measure Domains by Priority Area

PY 1 Priorities	Measure Domains
1. Delivery System Infrastructure	**1A.** Purchase or upgrade of ECM and ILOS IT systems and Provider capabilities including certified EHR technology, care management document systems, closed-loop referral, billing systems/services, and onboarding/enhancements to health information exchange capabilities
2. ECM Provider Capacity Building	**2A.** Building/expanding ECM Provider networks and compliance and oversight capabilities to ensure populations of focus within a county can be effectively served
	2B. Hiring and training ECM care managers, care coordinators, community health workers, and supervisors to ensure core competencies to support ECM requirements
3. ILOS Provider Capacity Building and ILOS Take-Up	**3A.** Offering ILOS, expanding reach of ILOS offered
	3B. Building/expanding ILOS Provider networks and compliance and oversight capabilities of ILOS to ensure populations within a county can be effectively served
	3C. Hiring and training ILOS Provider support staff, workflow redesign, and training
4. Quality	**4A.** Reporting of baseline data ("Pay for Reporting" only in Program Year 1) to inform quality outcome measures to be collected in future program years.

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High Performance Pool

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Distribution of High Performance Pool

DHCS plans to create a high-performance pool for unearned "Gate" and "Ladder" dollars. MCPs who qualify for the high performance pool and meet additional targets can earn incentive dollars above and beyond those dollars tied to "Gate" and "Ladder" measures.

- If a plan does earn the "Gate" advance/interim payment or does not meet sufficient "Ladder" measures to earn up to their cap (i.e., does not earn their maximum potential for incentive dollars), DHCS will reallocate the unearned dollars to a high performance pool that can be earned by other MCPs.
- An MCP's unearned "Ladder" measure incentive dollars would be eligible to be earned by other MCPs statewide who meet minimum standards and high performance pool targets.

High Performance Pool Eligibility

MCPs must meet minimum requirements to be eligible to earn high performance pool dollars; actual allocation of high performance pool dollars to be determined based on performance on measures and available funds, as evaluated during PY1 reporting periods.

High Performance Pool Minimum Requirements

- Meet all requirements to earn "Gate" interim payment/advance, and;
- Offer at least one ILOS, and;
- Perform in the top Xth percentage of MCPs for ladder measures across domains; percentile to be set by DHCS based on dollars available for high performance pool

High Performance Pool Measures

- Meet "stretch goal" targets for the "Ladder" measures already required across priority areas

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Consequences for Failure to Meet Requirements of “Payment Advance”

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Consequences for Failure to Meet Requirements of "Payment Advance"

Completion of Gap/Need Assessment and Gap-Filling Plan triggers an upfront, "Gate" payment "advance"/interim payment. MCPs must *implement* activities outlined in the Gap-Filling Plan to fully meet the "Gate" measure. DHCS reserves the right to recoup a portion of the advance from MCPs who fail to make a minimum level of effort to implement their Gap-Filling Plan.

- In PY1, DHCS will evaluate MCPs based on their results and achievement of process measures outlined in the Gap-Filling Plan.
- MCPs that fail to demonstrate a minimum level of effort, as determined by DHCS, must work with DHCS on a corrective action plan aimed at improving results and performance on the process measures.
- MCPs that fail to follow the corrective action plan and meet the minimum level of effort must return a portion of the "Gate" payment advance, to be determined by DHCS.

Thank you

Please visit the DHCS ECM & ILOS Website for more information and access to this deck as well as the Incentive Payment measure list: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx

Please send questions to CalAIMECMILOS@dhcs.ca.gov

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Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

13. Consider Approval of Program Year 1 CalAIM Performance Incentive Payment Methodology for Arta Western California, Inc., Monarch Health Plan, Inc., and Talbert Medical Group, P.C.

Contact

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

Recommended Actions

1. Approve Program Year (PY) 1 CalAIM Performance Incentive Payment Methodology for the Medi-Cal line of business for Arta Western California, Inc., Monarch Health Plan, Inc., and Talbert Medical Group, P.C., that defines measures and allocations effective January 1, 2022, through December 31, 2022;
2. Authorize the allocation and distribution of CalAIM Program Incentive Dollars for PY 1 to CalOptima and delegated health networks in accordance with the recommended methodology and in an aggregate amount for all health networks not to exceed $45 million; and
3. Authorize funding for and the distribution of incentive payments prior to CalOptima's receipt of CalAIM Program Incentive Dollars from the State of California.

Background

In preparation for the start of CalAIM's Enhanced Care Management (ECM) and In Lieu of Services (ILOS) programs on January 1, 2022, the California Department of Health Care Services (DHCS) will provide managed care plans with performance incentives to promote provider participation and capacity building. The state budget includes funding for incentive payments beginning on January 1, 2022 and ending in Fiscal Year (FY) 2024-25. Specifically, the state budget includes an allocation of $300 million for plan incentives from January 1, 2022, through June 30, 2022; $600 million for FY 2022-23; and $600 million for FY 2023-24. The incentive funding will phase out in FY 2024-25.

The initial PY 1 funding priority areas include:

- Delivery System Infrastructure;
- ECM Provider Capacity Building;
- ILOS Provider Capacity Building and managed care plan take-up; and
- Quality "Pay for Reporting" measures (which will be incorporated in the ECM provider capacity and ILOS provider capacity building priorities).

For PY 1, the state budget includes a $600 million allocation. DHCS plans to set a cap on the potential incentive dollars managed care plans may earn each program year and will provide a breakdown of the dollars across each priority area. These amounts will be based on total managed care enrollment and revenue. The actual payments earned by a plan in PY 1 will be based on the achievement of DHCS-specified "Gate" and "Ladder" milestones.

Discussion

In order to properly assess the delivery system infrastructure and ECM and ILOS provider capacity in Orange County, CalOptima is required to submit a "Gap Assessment and Gap Filling Plan" in Fall 2021.

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This plan will report to DHCS on baseline data and outlines CalOptima's implementation plan to address the identified gaps and needs. Attachment 2 provides information on DHCS' proposed milestones and measures.

DHCS Funding

On September 28, 2021, DHCS informed CalOptima that the amount of potential incentive dollars for PY 1 is approximately $45.0 million. This funding level accounts for the already existing Whole Person Care (WPC) and Health Homes Program (HHP) infrastructure in Orange County. DHCS plans to divide the timing of the PY 1 payments and the requirements for earning such payments into two (2); the first in January 2022 and the second in December 2022.

Payment 1: Anticipated January 2022

CalOptima management anticipates receiving half of the potential incentive amount or approximately $22.5 million in January 2022. DHCS intends managed care plans to use prepaid dollars to implement the activities outlined in the Gap Filling Plan. As such, CalOptima will need to complete the specified "Gate" requirements and report back to DHCS in Fall 2021. If CalOptima fails to make a minimum level of effort to implement their Gate-Filling Plan, DHCS reserves the right to recoup a portion of the prepaid funding.

Payment 2: December 2022

CalOptima management anticipates receiving the second half of the potential incentive amount or $22.5 million in December 2022. The state will measure CalOptima's performance against targets linked to the achievement of measures in the Gap Filling Plan (i.e., "Ladder" measures). CalOptima will need to report these measures to DHCS in Fall 2022 based on activities completed from January through June 2022.

CalOptima, in its capacity as a managed care plan, shall retain a portion of the incentive funding for retained ILOS risk. Staff estimates PY 1 funding of up to $14.5 million for this purpose. Up to $30.5 million in incentive funding will be distributed to health networks.

Health Networks

CalOptima Direct Networks (CCN/COD)

CCN/COD will be subject to the same allocation criteria as those described below.

Delegated Health Networks (HMO, PHC, SRG)

To ensure adequate revenue to support provider participation and capacity building, CalOptima will distribute incentive dollars consistent with DHCS guidance, based on the assumed delegated risk under CalAIM and contingent on the maximum potential incentive dollars as communicated by DHCS. CalOptima will employ the following to make incentive payments to delegated health networks.

Payment 1: A health network must be in good standing with CalOptima at the time of disbursement. Eligible health networks shall receive as prefunding, an allocation of the amount of incentive dollars

available. This allocation will take into account the anticipated delivery system infrastructure and ECM and ILOS provider capacity, as well as the level of delegated responsibility.

- CalOptima will distribute each health network's allocation upon completion of a final calculation. The allocation will include a fixed component of $250,000 per health network and variable components based on the health network's projected proportion by "populations of focus," as defined by DHCS; and
- CalOptima, at its sole discretion, may make annual or more frequent payments to health networks.

A health network shall submit a completed attestation form, signed by its Chief Executive Officer or Chief Financial Officer. CalOptima will provide a form that each health network can use to attest to the level of spending by PY 1 funding priority area. The health network's allocation of incentive dollars is as follows:

- 30% to Delivery System Infrastructure;
- 30% to ECM Provider Capacity Building;
- 15% to ILOS Provider Capacity Building; and
- 25% to health network discretion to one or more of the above priority areas.

Each health network shall participate in data collection, reporting activities and data submission to CalOptima, including measures for the Gap Assessment and Gap-Filling Plan and other subsequent data reporting requested by CalOptima. As of this writing, DHCS continues to develop and finalize guidance for the implementation of ECM and ILOS, including policy guidance for incentive payments and data sharing. Staff will return to the Board with additional information on measures and health network data sharing requirements pursuant to DHCS final guidance.

Payment 2: To qualify for funding, a health network must be in good standing with CalOptima at the time of disbursement.

- CalOptima will distribute each health network's allocation upon completion of a final calculation. The allocation will be based on demonstrated performance against measure targets and the projected health network proportion by "populations of focus," as defined by DHCS; and
- CalOptima, at its sole discretion, may make annual or more frequent payments to health networks.

Each health network shall participate in data collection, reporting activities and data submission to CalOptima, including measures for the "Ladder" measures and other subsequent data reporting requested by CalOptima.

In the event DHCS recoups any portion of the incentive funding due to a lack of effort to implement or to demonstrate performance against measure targets, CalOptima reserves the right to make subsequent recoupments from health networks. A health network shall participate in taking corrective actions and

submitting updates to CalOptima on process measures identified by DHCS through a corrective action plan to CalOptima.

Fiscal Impact

The fiscal impact of the PY 1 CalAIM performance incentive for the Medi-Cal line of business for January 1, 2022, through December 31, 2022, is projected to be budget neutral to CalOptima. The aggregate amount payable to all CalOptima and delegated health networks is not anticipated to exceed $45.0 million for PY 1. Staff anticipates any cash expended for the provider incentive payments will be replenished when CalAIM performance incentive dollars are received from DHCS.

Rationale for Recommendation

The recommended actions will enable CalOptima to support provider participation and capacity building in preparation of CalAIM ECM and ILOS programs.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. DHCS Proposed Milestones and Measures for CalAIM Incentive Payments (Draft for stakeholder feedback dated August 30, 2021)
3. CalAIM Performance Incentives (Draft for stakeholder feedback dated June 30, 2021)

/s/ Richard Sanchez — *10/28/2021*

Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima Medi-Cal Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245

DHCS

Proposed Milestones and Measures for CalAIM Incentive Payments
DRAFT - August 30, 2021

Priority	Percentage of Dollars (i.e., Max Cap) Allocated to Priority Area	Points Needed to Earn Max Payment 1	Points Needed to Earn Max Payment 2
1. Delivery System Infrastructure	Minimum 20%	200	200
2. ECM Provider Capacity Building	Minimum of 20%	200	200
3. ILOS Provider Capacity Building and ILOS Take-Up	Minimum of 30%	300	300
4. Quality	Optional measures with values allocated to either ECM or ILOS	N/A	To be allocated to ECM or ILOS based on measure
Total Points		700	700
MCP Discretion to Allocate to One or More Priority Areas	Up to 30% of Max Cap to be added to one or more of the above priority areas based on discretion of the plan, as reported in the Gap-Filling Plan template		

MCPs are required to submit information pertaining to the measures noted as mandatory, and can select among additional optional measures, to earn up to their full cap. DHCS will evaluate the MCP submissions and award payments proportional to the number of points earned per measure (as specified in the Reporting Template).MCPs are permitted and encouraged to work closely with providers and other stakeholders on these measures.

High Performance Pool: MCPs will receive payments from the high performance pool based on their performance against their individualized targets for each of their quantitative requirements reported as part of the submission for Payment 2. MCPs must meet minimum requirements to be eligible to earn high performance pool dollars, including:
-- Report on all mandatory requirements for the Gap/Need Assessment and Gap Filling Plan;
-- Offer at least three ILOS, and;
-- Demonstrate a minimum level of effort to implement their Gap-Filling Plan (i.e., are not placed on a corrective action plan).

Priority	Payment 1 Measures	Target for Payment 1 Measures	Optional / Mandatory for Payment 1	Weighting for Payment 1 Measures (Points Out of 700 Across Domains)	Payment 2 Measures	Target for Payment 2 Measure	Optional / Mandatory for Payment 2 Measures	Weighting for Payment 2 Measures (Points Out of 700 Across Domains)	Measure to Determine if Payment 1 is Fully Earned (i.e., Not Subject to Recoupment)?
1. Delivery System Infrastructure	Number and percent of contracted ECM Providers capable of electronically exchanging care plan information and clinical documents with other care team members	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted ECM Providers capable of electronically exchanging care plan information and clinical documents with other care team members	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Number and percent of contracted ECM Providers with access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted ECM Providers with access to certified EHR technology or a care management documentation systems able to generate and manage a patient care plan	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Number and percent of contracted ECM and ILOS Providers who are capable of submitting a claim or invoice to an MCP, or have access to a system or service that can process and send a claim or invoice to an MCP with information necessary for the MCP to submit a compliant encounter to DHCS	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted ECM and ILOS providers capable of submitting a claim or invoice to a MCP, or have access to a system or service that can process and send a claim or invoice to a MCP with information necessary for the MCP to submit a compliant encounter to DHCS	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Number and percent of contracted ILOS Providers for those ILOS offered by the MCP starting January 1, 2022 or July 1, 2022 who have access to closed-loop referral systems	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted ILOS Providers for those ILOS offered by the MCP starting January 1, 2022 or July 1, 2022 with access to closed-loop referral systems	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Number and percent of contracted behavioral health providers able to electronically exchange care plan information and clinical documents with other care team members	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted behavioral health providers able to electronically exchange care plan information and clinical documents with other care team members	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Submission of a narrative or joint MOU describing how the MCP will collaborate with other MCPs in the county to enhance and develop needed ECM/ILOS infrastructure, including certified EHR technology, care management document systems, closed-loop referral, billing systems/services, and onboarding/enhancements to health information exchange capabilities and submission of documentation demonstrating good faith efforts to begin this collaboration in the form of letters with MCPs in county, emails demonstrating progress, meeting meetings, or other documentation. If only one MCP is operating in the county, the MCP must submit a narrative describing how they will leverage and expand existing WPC capacity and support ongoing ECM and ILOS capacity building approaches	See reporting template for evaluation criteria for MOU	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Narrative describing how the MCP successfully collaborated with other MCPs in the county to enhance and develop needed ECM/ILOS infrastructure, including certified EHR technology, care management document systems, closed-loop referral, billing systems/services, and onboarding/enhancements to health information exchange capabilities	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Submission of a narrative Gap-Filling plan describing how MCPs will identify underserved populations and the ECM providers they are assigned to, and enhance those ECM Providers' capabilities to: (1) Electronically exchange care plan information and clinical documents with other care team members (2) Have access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan. (3) Submit a claim or invoice to an MCP, or have access to a system or service that can process and send a claim or invoice to an MCP with information necessary for the MCP to submit a compliant encounter to DHCS MCPs should also describe any plans to build physical plant infrastructure (e.g., sobering centers) to support the launch of ECM and ILOS. Gap-Filling Plan narrative should include approaches for collaborating with, Social Services, County Behavioral Health, and County/Local Public Health Agencies within the county to achieve the above activities, and should describe how health plans will leverage existing WPC infrastructure, including how they will track the ongoing viability of WPC infrastructure and improve data integration across behavioral health and physical health providers	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	80	Submission of a narrative demonstrating progress against Gap-Filling Plan, including identification of underserved populations and the ECM providers they are assigned to, and enhancements that have been made to those ECM Providers' capabilities to: (1) Electronically exchange care plan information and clinical documents with other care team members (2) Have access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan. (3) Submit a claim or invoice to an MCP, or have access to a system or service that can process and send a claim or invoice to an MCP with information necessary for the MCP to submit a compliant encounter to DHCS MCPs should also describe any progress to build physical plant infrastructure (e.g., sobering centers) to support the launch of ECM and ILOS. Narrative should outline progress on collaborations with Social Services, County Behavioral Health, and Counties/Local Public Health Agencies within the county to achieve the above activities, and should describe how health plans have leveraged existing WPC infrastructure and improved data integration across behavioral health and physical health providers.	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	80	**Yes**
2. ECM Provider Capacity Building	Number of contracted ECM Providers	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	20	Number of contracted ECM Providers	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	20	No
2. ECM Provider Capacity Building	Number of members identified as eligible to transition from HHP/WPC to ECM	N/A - Pay for Reporting	**Optional,** Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 points	Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 Points	Number of Members receiving ECM	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	10	No
2. ECM Provider Capacity Building	Number of Members across Program Year 1 Populations of Focus expected to require ECM. Break out of Members across Program Year 1 Populations of Focus expected to require ECM by race, ethnicity, and primary language.	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	10	Number of Members across Program Year 1 Populations of Focus receiving ECM. Break out of Members across Program Year 1 Populations of Focus receiving ECM by race, ethnicity, and primary language.	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	10	No
2. ECM Provider Capacity Building	Submission of a narrative or joint MOU describing how the MCP will collaborate with other MCPs in the county to support expansion of ECM Provider capacity, including leveraging and expanding existing WPC capacity and building/expanding ECM Provider networks and compliance and oversight capabilities. MCP should also submit documentation demonstrating good faith efforts to begin this collaboration in the form of letters with MCPs in county, emails demonstrating progress, meeting meetings, or other documentation. If only one MCP is operating in the county, the MCP must submit a narrative describing how they will leverage and expand existing WPC capacity and support ongoing ECM capacity building approaches	See reporting template for evaluation criteria for MOU	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	10	Narrative describing how the MCP successfully collaborated with other MCPs in the county to support ECM Provider capacity expansion, and leverage existing WPC capacity. If only one MCP is operating in the county, the narrative must describe how they successfully leveraged and expanded existing WPC capacity to support ECM capacity building	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	20	No
2. ECM Provider Capacity Building	Narrative summary that outlines landscape of Providers, faith-based groups, and community based organizations in the county and submission of a narrative plan to develop an MOU or other agreements with a subset of Providers, faith-based groups, county agencies and community based organizations in the county to develop strategies for closing health disparities experienced by Populations of Focus, including agreement to meet at least quarterly to advance strategy	See reporting template for evaluation criteria for narrative summary	**Optional,** Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 points	Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 Points	Submission of MOU or other collaborative agreement, associated agenda and meeting notes and narrative description of progress against narrative plan submitted as part of Payment 1 measure for the strategic partnership with the MCP, Providers, faith-based groups, county agencies and community based organizations to a develop strategy for closing health disparities experienced by Populations of Focus	See reporting template for evaluation criteria for MOU	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building	Narrative summary that outlines landscape of Tribes and Tribal providers used by members in the county and submission of a narrative plan to develop an MOU to establish a strategic partnership with Tribes and Tribal providers used by members in county to develop Provider capacity and provision of ECM services for members of Tribes	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 1 Tied to ECM Provider Capacity, except for Plans in Counties without recognized Tribes	30	Submission of MOU or other collaborative agreement, associated agenda and meeting notes and narrative description of progress against narrative plan submitted as part of Payment 1 measure, to demonstrate progress made to work with Tribes and Tribal providers used by members in county on Provider capacity and provision of ECM services for members of Tribes in county	See reporting template for evaluation criteria for MOU	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	20	No

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Priority	Payment 1 Measures	Target for Payment 1 Measures	Optional / Mandatory for Payment 1	Weighting for Payment 1 Measures (Points Out of 700 Across Domains)	Payment 2 Measures	Target for Payment 2 Measure	Optional / Mandatory for Payment 2 Measures	Weighting for Payment 2 Measures (Points Out of 700 Across Domains)	Measure to Determine if Payment 1 is Fully Earned (i.e., Not Subject to Recoupment)?
2. ECM Provider Capacity Building	Submission of narrative plan describing how the managed care plan will improve outreach to and engagement with the following Population of Focus: "*people experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless with complex health and/or behavioral health conditions,* " with a focus on Black/African American and other racial and ethnic groups who are disproportionately experiencing homelessness	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	30	Baseline data for individuals who are Black/African American and from other racial and ethnic groups who are disproportionately experiencing homelessness and who meet the Population of Focus definition: "*people experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless with complex health and/or behavioral health conditions* " **and narrative summary** of progress the MCP made to improve outreach to and engagement with individuals who are Black/African American and other racial and ethnic groups who are disproportionately experiencing homelessness	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	20	No
2. ECM Provider Capacity Building	Submission of narrative plan describing how the managed care plan will improve outreach to and engagement with the following Population of Focus: "individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of sevices to the community," with a focus on Black/African American and other racial and ethnic groups who are disproportionately experiencing transitions from incarceration settings in the county	See reporting template for evaluation criteria for narrative summary	**Optional,** Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 points	Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 Points	Baseline data for individuals who are Black/African American and from other racial and ethnic groups who disproportionately meet the Population of Focus definition: "*individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community* " who have been successfully outreached to and engaged by an ECM Provider and **narrative summary** of progress the MCP made to improve outreach to and engagement with Black/African American and other racial and ethnic groups who are disproportionately experiencing transitions from incarceration settings	N/A - Pay for Reporting	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building	Reporting on racial and ethnic demographics of ECM Providers for each Program Year 1 Populations of Focus relative to the racial and ethnic demographics of the Members in each Program Year 1 Populations of Focus	N/A - Pay for Reporting	**Optional,** Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 points	Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 Points	Reporting on racial and ethnic demographics of ECM Providers for each Program Year 1 Populations of Focus relative to the racial and ethnic demographics of the beneficiaries in the Program Year 1 Populations of Focus	N/A - Pay for Reporting	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building					Hired full time Health Equity Officer by July 1, 2022 who has the necessary qualifications or training at the time of hire or within 1 year of hire to meet the requirements of the position, as outlined in the MCP Procurement	N/A - Pay for Reporting	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building					Rates of sharing ECM assessment and care plan information across physical and behavioral health care teams	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	10	No
2. ECM Provider Capacity Building	Submission of a narrative Gap-Filling plan describing: (1) How the MCP will address identified gaps in ECM Provider capacity for Program Year 1 Populations of Focus (2) Identified ECM workforce, training, TA needs in county, including specific cultural competency needs by county (3)Plan for ECM Provider workforce recruiting and hiring of necessary staff to build capacity (4) Approach for MCP to develop and administer an MCP training and TA program for ECM Providers (5) Strategy to ensure ECM Providers are successfully engaging with hard to reach Populations of Focus, including homeless and justice involved populations, among others Gap-Filling Plan narrative should include approach for collaborating with Social Service, County Behavioral Health, County/Local Public Health Agencies, Tribes and Tribal providers (except for Plans in Counties without recognized Tribes), community based organizations and ECM Providers to achieve the above activities, improve outreach to and engagement with hard to reach individuals within each Populations of Focus and reduce underlying health disparities	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	70	Submission of a narrative describing progress against Gap-Filling plan, including: (1) Progress in increasing ECM Provider capacity and MCP oversight capacity (1) Progress in addressing ECM workforce, training, TA needs in county, including specific cultural competency needs by county (2) Progress in supporting ECM Provider workforce recruiting and hiring of necessary staff to build capacity (3) Progress in developing and administering a MCP training and TA program for ECM Providers (4) Progress in successfully engaging with hard to reach Populations of Focus, including homeless and justice involved populations, among others Narrative should outline progress and results from collaborations with County Social Service, Behavioral Health, County/Local Public Health Agencies, Tribes and Tribal providers (except for Plans in Counties without recognized Tribes), community based organizations and ECM Providers to achieve the above activities, improve outreach to and engagement with hard to reach individuals within each Populations of Focus and reduce underlying health disparities.	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	60	**Yes**
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Plan All-Cause Readmissions (PCR)** For beneficiaries ages 18 to 64 who are in the ECM populations of focus, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: • Count of Index Hospital Stays (IHS) • Count of Observed 30-Day Readmissions • Count of Expected 30-Day Readmissions	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Ambulatory Care—Emergency Department Visits (AMB-ED)** Rate of emergency department (ED) visits per 1,000 beneficiary months for beneficiaries who are in the ECM populations of focus	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Depression Screening and Follow-Up for Adolescents and Adults (DSF)** The percentage of beneficiaries 12 years of age and older who are in the ECM populations of focus and who were screened for clinical depression using a standardized tool and, if screened positive, who received follow-up care.	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)** The percentage of members 12 years of age and older with a diagnosis of depression, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Follow-Up After Emergency Department Visit for Mental Illness (FUM)** Percentage of emergency department (ED) visits for beneficiaries age 18 and older who are in the ECM populations of focus and who have a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)** Percentage of emergency department (ED) visits for beneficiaries age 18 and older who are in the ECM populations of focus and have a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: • Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) • Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Controlling High Blood Pressure (CBP)** Percentage of beneficiaries ages 18 to 85 who are in the ECM populations of focus and who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)** Percentage of children ages 1 to 17 who are in the ECM populations of focus and who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: • Percentage of children and adolescents on antipsychotics who received blood glucose testing • Percentage of children and adolescents on antipsychotics who received cholesterol testing • Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
3. ILOS Provider Capacity Building and ILOS Take-Up	Number of contracted ILOS Providers	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up	20	Number of contracted ILOS Providers	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	20	No

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Priority	Payment 1 Measures	Target for Payment 1 Measures	Optional / Mandatory for Payment 1	Weighting for Payment 1 Measures (Points Out of 700 Across Domains)	Payment 2 Measures	Target for Payment 2 Measure	Optional / Mandatory for Payment 2 Measures	Weighting for Payment 2 Measures (Points Out of 700 Across Domains)	Measure to Determine if Payment 1 is Fully Earned (i.e., Not Subject to Recoupment)?
3. ILOS Provider Capacity Building and ILOS Take-Up	Number of members identified as eligible to transition from HHP/WPC to ILOS	N/A - Pay for Reporting	**Optional,** Report on One Optional Payment 1 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 50 points	Report on One Optional Payment 1 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 50 Points	Number of Members receiving ILOS	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	20	No
3. ILOS Provider Capacity Building and ILOS Take-Up	Offer ILOS housing suite: housing transition navigation, housing deposits, housing tenancy and sustaining services, short-term post-hospitalization housing, day habilitation programs, and medical respite starting in January 2022 or July 2022	N/A - MCPs must offer the full ILOS housing suite to earn incentive dollars tied to this measure	**Optional,** Report on One Optional Payment 1 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 50 points	Report on One Optional Payment 1 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 50 Points					
3. ILOS Provider Capacity Building and ILOS Take-Up	Number of ILOS offered county-wide by the MCP starting January 2022 or July 2022 *If the ILOS Provider network/capacity will not reasonably allow for county-wide provision of ILOS to all eligible Members in the county at the time of implementation, please provide additional information in the Gap-Filling Plan. DHCS will review the information provided to determine if the county-wide provision of a given ILOS is not a reasonable expectation and work with the MCP to assess if a given ILOS not offered county-wide will count toward this measure.*	Evaluated based on number of ILOS offered county-wide: 1-4 = 60 points 5-7 = 70 point 8+ = 80 points	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up	Points awarded based on number of ILOS offered: 1-4 = 60 points 5-7 = 70 point 8+ = 80 points					
3. ILOS Provider Capacity Building and ILOS Take-Up	Narrative summary that outlines landscape of Tribes and Tribal providers used by members in the county and submission of a narrative plan to develop an MOU to establish a strategic partnership with Tribes and Tribal providers used by members in county to develop Provider capacity and provision of provision of ILOS for members of Tribes in county	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up, except for Plans in Counties without recognized Tribes	20	Submission of MOU or other collaborative agreement, associated agenda and meeting notes and narrative description of progress against narrative plan submitted as part of Payment 1 measure, to demonstrate progress made to work with Tribes and Tribal providers used by members in county on Provider capacity and provision of ILOS for members of Tribes and Tribal providers used by members in county	See reporting template for evaluation criteria for MOU	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	20	No
3. ILOS Provider Capacity Building and ILOS Take-Up					Percent of enrollees receiving ILOS by race, ethnicity, and primary language, relative to the demographics in the underlying enrollee population	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	50	No
3. ILOS Provider Capacity Building and ILOS Take-Up	Submission of a narrative or joint MOU describing how the MCP will collaborate with other MCPs in the county to leverage and expand existing WPC capacity and support ongoing ILOS capacity building approaches. MCP should also submit documentation demonstrating good faith efforts to begin this collaboration in the form of letters with MCPs in county, emails demonstrating progress, meeting meetings, or other documentation. If only one MCP is operating in the county, the MCP must submit a narrative describing how they will leverage and expand existing WPC capacity and support ongoing ILOS capacity building approaches	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up	50	Narrative describing how the MCP successfully collaborated with other MCPs in the county to leverage and expand existing WPC capacity and support ongoing ILOS capacity building approaches. If only one MCP is operating in the county, the MCP must submit a narrative describing how they successfully leveraged and expanded existing WPC capacity to support ongoing ILOS capacity building approaches.	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	50	No
3. ILOS Provider Capacity Building and ILOS Take-Up	Submission of a narrative Gap-Filling plan describing: (1) Identified gaps or limitations in ILOS coverage within county (2) Plan to increase number and/or reach of ILOS offered in January 2022 or July 2022 (3) Identified ILOS Provider capacity and MCP oversight capability gaps and plan to address gaps (4) Identified ILOS workforce, training, TA needs in region / county, including specific cultural competency needs by region/county (5) Plan to develop and administer a training and TA program for ILOS Providers (6) Plan to establish programs to support ILOS workforce recruiting and hiring, including incentives for ILOS Providers to hire necessary staff Gap-Filling Plan narrative should include approach for collaborating with Social Service, County Behavioral Health, County/Local Public Health Agencies, and ILOS Providers to achieve the above activities, improve outreach to and engagement with hard to reach individuals and reduce underlying health disparities.	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up	80	Submission of a narrative demonstrating progress against Gap-Filling plan, including: (1) Reduced gaps or limitations in ILOS coverage across county (2) Increased number and/or reach of ILOS offered in January 2022 or July 2022 (3) Reduction in ILOS Provider capacity and MCP oversight capability gaps (4) Resolution of ILOS workforce, training, TA needs in region / county, including specific cultural competency needs by region/county (5) Successfully administered training and TA program for ILOS Providers (6) Demonstrated support for ILOS workforce recruiting and hiring Narrative should outline progress and results from collaborations with County Social Service, Behavioral Health, County/Local Public Health Agencies, and ILOS Providers to achieve the above activities, improve outreach to and engagement with hard to reach individuals, and reduce underlying health disparities.	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	120	Yes
3. ILOS Provider Capacity Building and ILOS Take-Up *Quality Measure*					**Submission of baseline data for Asthma Medication Ratio** The percentage of beneficiaries ages 5 to 64 who are receiving ILOS, 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	N/A - Pay for Reporting in CY 2022	**Optional,** Report on One Optional Payment 2 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 20 points	Report on One Optional Payment 2 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 20 Points	No

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CalAIM Performance Incentives

DRAFT for Stakeholder Feedback

June 30, 2021

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- Overview of Incentive Payment Approach
- Allocation Methodology and Timing
- Payment Priorities and Measure Domains
- High Performance Pool
- Consequences for Failure to Meet Requirements of "Gate Payment Advance"
- Questions

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Overview

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CalAIM Performance Incentives Overview

CalAIM's Enhanced Care Management (ECM) and In Lieu Of Services (ILOS) programs will launch in January 2022, requiring significant new investments in care management capabilities, ILOS infrastructure, information technology (IT) and data exchange, and workforce capacity at both the managed care plan (MCP) and provider levels.

- Incentive payments will be a critical component of CalAIM to promote MCP and provider participation in, and capacity building for, ECM and ILOS.
- The Governor's budget allocated $300 million for plan incentives from January to June 2022, $600 million from July 2022 to June 2023, and $600 million from July 2023 to June 2024. Incentive funding will phase out in FY 2024-25.
- DHCS has designed the proposed incentive payment approach with input from stakeholders with the goal of issuing initial payments to MCPs beginning in January 2022 for the achievement of defined milestones.

Performance Incentive Goals

- **Build appropriate and sustainable ECM and ILOS capacity**
- **Drive MCP investment in necessary delivery system infrastructure**
- **Incentivize MCP take-up of ILOS**
- **Bridge current silos across physical and behavioral health delivery**
- **Reduce health disparities and promote health equity**
- **Achieve improvements in quality performance**

Infrastructure development, ECM and ILOS Provider capacity building, and ILOS take-up are priority areas for Program Year (PY)1 (i.e., Calendar Year (CY) 2022). DHCS will incorporate behavioral and physical health integration and health disparities reduction measures within those priority areas.

Quality "pay for reporting" measures will be incorporated into the ECM Provider Capacity and ILOS Provider Capacity priorities in PY 1 (i.e. CY 2022). Quality outcome measures will be incorporated in PY 2 (i.e., CY 2023) and beyond.

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Performance Incentive Design Principles

1. Develop a clear incentive payment allocation methodology where all plans have an opportunity to participate equitably
2. Set ambitious, yet achievable measure targets
3. Ensure efficient and effective use of all performance incentive dollars
4. Drive significant investments in core priority areas up front
5. Minimize administrative complexity
6. Address variation in existing infrastructure and capacity between Whole Person Care (WPC) / Health Home Program (HHP) counties and non-WPC/HHP counties
7. Ensure use of incentive dollars does not overlap with other DHCS incentive programs or with services funded through the rates
8. Measure and report on the impact of incentive funds

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Incentive Payment Allocation Methodology

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Allocating Incentive Dollars to MCPs in Program Year 1

DHCS plans to set a cap on the maximum potential incentive dollars that can be earned by an MCP in each program year. Actual payments earned by an MCP would be based on achievement of "Gate" and "Ladder" Milestones.

"Gate" Milestone Linked to 50% of Available Dollars in PY1

- Consists of submission of "Gap Assessment and Gap-Filling Plan" measures outlining implementation approach to address gaps and needs.
- Completion of "Gate" requirements triggers upfront, incentive payment "advance" / interim payment.
- Advance / interim payment intended to be used to implement activities outlined in the Gap-Filling Plan.
- DHCS will recoup a portion of the advance from MCPs who fail to make a minimum level of effort to implement their Gap-Filling Plan.

"Ladder" Milestones Linked to 50% of Available Dollars in PY1

- Demonstrated performance against measure targets linked to achievement of "Gap-Filling Plan" targets.
- Achievement of "Ladder" measure targets result in subsequent incentive payments.

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Timing of PY1 Payments

DHCS proposes a bi-annual payment cycle to issue $600M in payments to MCPs in PY1 (CY 2022).

January 2022 Payment

- DHCS issues 50% of available dollars ($300 M)
- Tied to completion of “Gate” requirements
- “Gate” requirements to be completed and reported by MCPs in fall 2021

December 2022 Payment

- DHCS issues 50% of available dollars ($300 M)
- Tied to completion of second set of “Ladder” measures, which will be based on PY 1 priority areas
- “Ladder” measures to be submitted by MCPs in fall 2022, based on activity from January – June 2022

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DHCS Will Set Cap on *Maximum Potential* Incentive Dollars Each MCP Can Earn

DHCS plans to establish a three-step process to set the cap on the *maximum potential* amount of incentive dollars each MCP can earn. Incentive payments *actually earned* by MCPs will be determined by performance on measures.

- **Step 1.** Set maximum **potential** incentive amount that can be earned **across MCPs within a given county** based on total managed care enrollment or revenue
  - ***Adjustment:*** Increase potential payments in counties without WPC/HHP
- **Step 2.** Set maximum **potential** amount that can be earned **by each MCP within a given county** based on their managed care enrollment or revenue
  - ***Adjustment*:** Increase potential payments based on proportion of enrollees who are members of the ECM populations of focus
- **Step 3.** Set **potential** amount available to be earned **across priority areas** for PY1 (CY 2022) (see Slide 11 for detail on allocation by priority)
  - ***Priority areas*:** 1) Infrastructure development; 2) ECM capacity; 3) ILOS uptake and capacity

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Allocation of Dollars by Priority Area

MCPs will have some flexibility to propose the percentage of their cap that can be earned in each priority area based on a submission to DHCS as part of their Gap-Filling Plans. Final determinations will be made by DHCS.

- MCPs will propose the percentage of their cap that can be earned in each priority area based on the following methodology:
  - **70% of the cap must be allocated as follows:**
    - *Minimum of 20% tied to Delivery System Infrastructure measures*
    - *Minimum of 20% tied to ECM Provider capacity building measures* [2]
    - *Minimum of 30% tied to ILOS Provider capacity building and take-up measures* [1,2]
  - **Remaining 30% is allocated at the plans discretion to one or more areas**
    - MCPs who want to request more than the 30% allocated for discretionary use will need to provide their rationale to DHCS as soon as possible; DHCS may consider granting exceptions in very limited cases where the MCP's rationale is compelling
- **DHCS must ultimately approve the approach via review of Gap-Filling Plan**

[1] In CY 2022 (PY 1), MCPs are eligible to earn a "Gate" payment for ILOS if offering ILOS in January 2022 ***or*** *July 2022*

[2] Quality "pay for reporting" measures will be incorporated into the ECM Provider Capacity and ILOS Provider Capacity priorities

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Incentive Payment Priorities and Measure Domains

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Program Year 1 Priorities

DHCS focused initial PY 1 (i.e., CY 2022) funding priority areas* on capacity building, infrastructure, and ILOS take-up.

Delivery System Infrastructure	ECM Provider Capacity Building	ILOS Provider Capacity Building & MCP Take-Up
Fund core MCP, ECM and ILOS Provider HIT and data exchange infrastructure required for ECM and ILOS	*Fund ECM workforce, training, TA, workflow development, operational requirements and oversight*	*Fund ILOS training, TA, workflow development, operational requirements, take-up and oversight*

Physical and behavioral health integration between and among Providers and MCPs, health equity advancement, and health disparities reduction have been integrated into all three goal areas wherever feasible.

** Quality "pay for reporting" measures will be incorporated into the ECM Provider Capacity and ILOS Provider Capacity priorities in PY 1 (i.e. CY 2022). Quality outcome measures will be incorporated in PY 2 (i.e., CY 2023) and beyond.*

Measure Domains by Priority Area

PY 1 Priorities	Measure Domains
1. Delivery System Infrastructure	**1A.** Purchase or upgrade of ECM and ILOS IT systems and Provider capabilities including certified EHR technology, care management document systems, closed-loop referral, billing systems/services, and onboarding/enhancements to health information exchange capabilities
2. ECM Provider Capacity Building	**2A.** Building/expanding ECM Provider networks and compliance and oversight capabilities to ensure populations of focus within a county can be effectively served
	2B. Hiring and training ECM care managers, care coordinators, community health workers, and supervisors to ensure core competencies to support ECM requirements
3. ILOS Provider Capacity Building and ILOS Take-Up	**3A.** Offering ILOS, expanding reach of ILOS offered
	3B. Building/expanding ILOS Provider networks and compliance and oversight capabilities of ILOS to ensure populations within a county can be effectively served
	3C. Hiring and training ILOS Provider support staff, workflow redesign, and training
4. Quality	**4A.** Reporting of baseline data ("Pay for Reporting" only in Program Year 1) to inform quality outcome measures to be collected in future program years.

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High Performance Pool

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Distribution of High Performance Pool

DHCS plans to create a high-performance pool for unearned "Gate" and "Ladder" dollars. MCPs who qualify for the high performance pool and meet additional targets can earn incentive dollars above and beyond those dollars tied to "Gate" and "Ladder" measures.

- If a plan does earn the "Gate" advance/interim payment or does not meet sufficient "Ladder" measures to earn up to their cap (i.e., does not earn their maximum potential for incentive dollars), DHCS will reallocate the unearned dollars to a high performance pool that can be earned by other MCPs.
- An MCP's unearned "Ladder" measure incentive dollars would be eligible to be earned by other MCPs statewide who meet minimum standards and high performance pool targets.

High Performance Pool Eligibility

MCPs must meet minimum requirements to be eligible to earn high performance pool dollars; actual allocation of high performance pool dollars to be determined based on performance on measures and available funds, as evaluated during PY1 reporting periods.

High Performance Pool Minimum Requirements

- Meet all requirements to earn "Gate" interim payment/advance, and;
- Offer at least one ILOS, and;
- Perform in the top Xth percentage of MCPs for ladder measures across domains; percentile to be set by DHCS based on dollars available for high performance pool

High Performance Pool Measures

- Meet "stretch goal" targets for the "Ladder" measures already required across priority areas

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Consequences for Failure to Meet Requirements of “Payment Advance”

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Consequences for Failure to Meet Requirements of "Payment Advance"

Completion of Gap/Need Assessment and Gap-Filling Plan triggers an upfront, "Gate" payment "advance"/interim payment. MCPs must *implement* activities outlined in the Gap-Filling Plan to fully meet the "Gate" measure. DHCS reserves the right to recoup a portion of the advance from MCPs who fail to make a minimum level of effort to implement their Gap-Filling Plan.

- In PY1, DHCS will evaluate MCPs based on their results and achievement of process measures outlined in the Gap-Filling Plan.
- MCPs that fail to demonstrate a minimum level of effort, as determined by DHCS, must work with DHCS on a corrective action plan aimed at improving results and performance on the process measures.
- MCPs that fail to follow the corrective action plan and meet the minimum level of effort must return a portion of the "Gate" payment advance, to be determined by DHCS.

Thank you

Please visit the DHCS ECM & ILOS Website for more information and access to this deck as well as the Incentive Payment measure list: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx

Please send questions to CalAIMECMILOS@dhcs.ca.gov

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Authorizing CalOptima Ancillary Services Contract with Whole Person Care and Health Homes Program Providers for the Provision of Community Supports Services

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
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Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into CalOptima ancillary services contracts with providers currently engaged in the County of Orange's (County) Whole Person Care (WPC) program and CalOptima's Health Homes Program (HHP), for the provision of Community Supports Services, effective January 1, 2022.

Background

On January 8, 2021, the Department of Health Care Services (DHCS) released a revised California Advancing and Innovating Medi-Cal (CalAIM) proposal that takes a whole-person care approach to improving health outcomes for Medi-Cal members by incorporating both clinical and nonclinical services. Implementation of CalAIM initiatives by managed care plans spans five years, beginning January 1, 2022. Two key CalAIM initiatives are Enhanced Care Management (ECM) and Community Supports Services. ECM creates a single, intensive and comprehensive benefit that is designed to meet the needs of CalOptima's most vulnerable members. Community Supports Services are medically appropriate, cost-effective alternatives that are provided as a substitute for services covered under the California Medicaid State Plan and are delivered by a different provider or in a different setting than those described in the State plan. ECM and Community Supports Services are optional for members. CalOptima and delegated health networks will provide ECM services, and the current WPC and HHP providers will deliver Community Supports Services. For the initial launch of CalAIM, and to ensure a smooth transition for WPC and HHP members, CalOptima will offer the following Community Supports Services currently offered through the County's WPC and CalOptima's HHP:

- Housing Transition Navigation Services
- Housing Tenancy and Sustaining Services
- Housing Deposits
- Recuperative Care (Medical Respite)

Following the initial January 1, 2022, implementation of ECM and Community Supports Services, staff will explore expanding the network of providers and Community Supports Services offerings and will return to this Board for future consideration.

Discussion

For the provision of Community Supports Services, effective January 1, 2022, CalOptima will contract with the same eight providers currently engaged in providing these services under the County's WPC

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and CalOptima's HHP. The following provides additional detail on the Community Supports Services that CalOptima will offer for qualified members.

Housing Transition Navigation Services
Housing Transition Navigation Services are designed to assist highly vulnerable members obtain housing. Eligible members are those experiencing homelessness and/or disabilities, serious chronic conditions, mental illness or institutionalization. Services include, but are not limited to, identifying barriers to successful tenancy, developing individualized housing support plans, searching for housing, support and assistance with moving, and educating and engaging with landlords.

Housing Tenancy and Sustaining Services
Housing Tenancy and Sustaining Services are a series of services to help members maintain safe and stable tenancy once housing is secured. These include, but are not limited to, identification and intervention of behaviors that may jeopardize housing, coordination with landlords and case management providers to address issues that could impact housing, and health and safety visits including habitability inspections. The ultimate goal of these services is to provide members experiencing homelessness and/or complex health issues (including behavioral health issues) with best practices for continued tenancy.

Housing Deposits
Housing deposits are monetary assistance for homeless members to cover one-time services and costs required for establishing basic housing. These include, but are not limited to, security deposits, utilities set-up fees and first and last months' rent. Housing deposits are targeted to members experiencing homelessness as well as complex health conditions (including behavioral health conditions) and/or disabilities. The service is provided in conjunction with Housing Transition Navigation Services.

Recuperative Care (Medical Respite)
Recuperative care (or "medical respite") is intended for members living alone who lack formal support, face housing insecurity, are at risk of hospitalization, are in post-hospitalization or live in housing conditions that jeopardize their health and safety. This service will provide members a stable environment to stay for an extended period of time, typically at a short-term residential care facility. Included in this recovery care setting is the continuation of post-hospital discharge treatment along with primary care, behavioral health services and case management.

Staff recommends contracting with providers currently engaged in the County's WPC and CalOptima's HHP for the provision of these Community Supports Services, effective January 1, 2022.

Fiscal Impact
The recommended action to execute contracts for ancillary services with providers currently engaged in the County WPC or CalOptima's HHP to provide Community Supports Services effective January 1, 2022, is a budgeted item under the CalOptima Fiscal Year (FY) 2021-22 Operating Budget approved by the Board on June 3, 2021. Staff anticipates the fiscal impact to be budget neutral. According to DHCS's assumptions, decreased utilization will be sufficient to support the additional cost for Community Supports Services.

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Rationale for Recommendation

Approving the ancillary services contract for Community Supports Services providers will ensure CalOptima's Medi-Cal members have access to medically appropriate, alternative services provided under CalAIM.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Proposed Ancillary Services Contract

/s/ Richard Sanchez *10/28/2021*

Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
American Family Housing dba Orange County Housing Collaborative (aka Housing for Health OC)	15161 Jackson St.	Midway City	CA	92655
(American Family Housing)	15161 Jackson St.	Midway City	CA	92655
(Friendship Shelter)	24361 El Toro Rd.	Laguna Woods	CA	92637
(Jamboree Housing)	17701 Cowan Ave., Suite 200	Irvine	CA	92614
(Mercy House Living Centers)	P.O. Box 1905	Santa Ana	CA	92702
Blue Sky Manor, Inc.	280 N. Wilshire Blvd.	Anaheim	CA	92801
Community Action Partnership of Orange County	11870 Monarch St.	Garden Grove	CA	92841
(Southwest Community Ctr.)	1601 W. 2nd St.	Santa Ana	CA	92703
(El Modena Family Resource Ctr.)	18672 E. Center Ave.	Orange	CA	92869
(Anaheim Independencia Family Resource Ctr.)	10841 Garza Ave.	Anaheim	CA	92804
Illumination Foundation	1091 Batavia St.	Orange	CA	92867
Lutheran Social Services of Southern California	247 East Amerige Ave.	Fullerton	CA	92832
Mom's Retreat Recuperative Care	607 S. Pine Drive	Fullerton	CA	92833
Volunteers of America Los Angeles	2100 N Broadway Str. Suite 300	Santa Ana	CA	92706

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ANCILLARY SERVICES CONTRACT

This Ancillary Services Contract (the "Contract") is entered into by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and **[Provider Name]** ("Provider"), with respect to the following:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State of California, Department of Health Care Services ("DHCS") ("DHCS Contract"), pursuant to which it is obligated to arrange and pay for the provision of health care services to certain Medi-Cal eligible beneficiaries in Orange County (referred to herein as the "Medi-Cal Program").

C. "DHCS is adding Enhanced Care Management (ECM) services to the Medi-Cal benefit set, effective January 1, 2022, and transitioning the Whole Person Care (WPC) and the Health Homes Program (HHP) to ECM."

D. Provider is a provider of the items and services described in this Contract and has all certifications, licenses and permits necessary to furnish such items and services.

E. CalOptima desires to engage Provider to furnish, and Provider desires to furnish, certain items and services to CalOptima Members as described herein. CalOptima and Provider desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
DEFINITIONS

The following definitions, and any additional definitions set forth in Attachments and Schedules attached hereto, apply to the terms set forth in this Contract:

1.1 "Cal MediConnect" means a program to furnish health care services to Medicare/Medi-Cal members who are enrolled in CalOptima's Cal MediConnect Program. Cal MediConnect is also referred to as OneCare Connect.

1.2 "California Children's Services (CCS)" means those services authorized by the CCS Services Program for the diagnosis and treatment of the CCS Services Eligible Conditions of a specific Member.

1.3 "CalOptima Community Network" or "CCN" means CalOptima's direct health network that serves members who are enrolled in it pursuant to CalOptima Policies. CCN Members are assigned to Primary Care Providers as their medical home, and their care is coordinated through the PCP.

1.4 "CalOptima Direct" or "COD" means a program CalOptima administers for CalOptima beneficiaries not enrolled in a Health Network. COD consists of two components:

1.4.1 CalOptima Direct Members who are assigned to CalOptima Community Network (CCN) in accordance with CalOptima Policy. Members are assigned to Primary Care Physicians (PCP) as their medical home, and their care is coordinated through their PCP in CCN.

1.4.2 "CalOptima Direct-Administrative" or "COD-Administrative" provides services to Members who reside outside of CalOptima's service area, are transitioning into a Heath Network, have a Medi-Cal Share of Cost, or are eligible for both Medicare and Medi-Cal. These Members are free to select any registered Practitioner for Physician services.

1.5 "CalOptima Policies" means CalOptima policies and procedures relevant to this Contract, as amended from time to time at the sole discretion of CalOptima.

1.6 "CalOptima Programs" means the Medi-Cal, OneCare, Program of All-Inclusive Care for the Elderly (PACE) and Cal MediConnect (OneCare Connect) programs administered by CalOptima. Provider participates in the specific CalOptima Program(s) identified on Attachment A.

1.7 "CalOptima's Regulators" means those government agencies that regulate and oversee CalOptima's and its first tier downstream and/or related entity's ("FDR's") activities and obligations under this Contract including, without limitation, the Department of Health and Human Services Inspector General, the Centers for Medicare and Medicaid Services, the California Department of Health Care Services, and the California Department of Managed Health Care, the Comptroller General and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract.

1.8 "Claim" means a request for payment submitted by Provider in accordance with this Contract and CalOptima Policies.

1.9 "Clean Claim" means a Claim that has no defects or improprieties, contains all required supporting documentation, passes all system edits, and does not require any additional reviews by medical staff to determine appropriateness of services provided as defined in the CalOptima Program(s).

1.10 "Community Supports" means "in-lieu of services", as set forth in 42 CFR § 438.3(e)(2), services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to the State Plan Covered Services. Community Supports are optional for both CalOptima and the Member must be approved by the DHCS and are authorized and identified in CalOptima's Medi-Cal Contract with DHCS. Effective no sooner than January 1, 2022, CalOptima shall offer the following four (4) selected DHCS-approved Community Supports, as further defined in CalOptima Policy GG.1355: Community Supports: (i) Housing Transition Navigation Services; (ii) Housing Deposits; (iii) Housing Tenancy and Sustaining Services; and (iv) Recuperative Care (Medical Respite). For purposes of this Contract, the Community Supports Provider shall offer to Members the DHCS-approved Community Supports described in Attachment A of this Contract.

1.11 "Community Supports Provider" means the Provider when providing DHCS-approved Community Supports to Members pursuant to this Contract. The Provider shall have the experience and/or

training in providing the DHCS-approved Community Supports described in Attachment A of this Contract.

1.12 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of the members of its Board of Directors, employees, contractors and providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan.

1.13 "Coordination of Benefits" or "COB" refers to the determination of order of financial responsibility which applies when two or more health benefit plans provide coverage of items and services for an individual.

1.14 "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the DHCS Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Covered Services shall also include CCS Services (as defined in Subdivision 7 of Division 2 of Title 22 of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

1.15 "ECM Provider" means CalOptima Direct or Health Network, as applicable, when providing ECM services to their assigned ECM Members under CalOptima's Medi-Cal Program.

1.16 "Effective Date" means the effective date of commencement of the Contract as provided in Article 10.

1.17 "Encounter Data" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators."

1.18 "Enhanced Care Management" or "ECM" means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, high-touch, and person-centered. ECM is a Medi-Cal benefit.

1.19 "Government Agencies" means Federal and State agencies that are parties to the Government Contracts including, HHS/CMS, DHCS, DMHC and their respective agents and contractors, including quality improvement organizations (QIOs).

1.20 "Government Contract(s)" means the written contract(s) between CalOptima and the Federal and/or State government pursuant to which CalOptima administers and pays for covered items and services under a CalOptima Program.

1.21 "Government Guidance" means Federal and State operational and other instructions related to the coverage, payment and/or administration of CalOptima Program(s).

1.22 "Health Network" means a physician group, physician-hospital consortium or health care service plan, such as an HMO, which is contracted with CalOptima to provide items and services to non-COD Members on a capitated basis.

1.23 "Licenses" means all licenses and permits that Provider is required to have in order to participate in the CalOptima Programs and/or furnish the items and/or services described under this Contract.

1.24 "Medi-Cal" is the name of the Medicaid program for the State of California (*i.e.,* the program authorized by Title XIX of the Federal Social Security Act and the regulations promulgated thereunder).

1.25 "Medically Necessary" or "Medical Necessity" means reasonable and necessary services to protect life, to prevent illness or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22, CCR Section 51303 (a) and 42 CFR 438.210 (a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132(v).

1.26 "Medicare" means the Federal health insurance program defined in Title XVIII of the Federal Social Security Act and regulations promulgated thereunder.

1.27 "Medicare Secondary Payer" or "MSP" means the Medicare coordination of benefits requirements as incorporated in MA regulations.

1.28 "Member" means any person who has been determined to be eligible to receive benefits from, and is enrolled in, one or more CalOptima Program. Member may also be referred to as Enrollee or Participant depending on the CalOptima Program.

1.29 "Memorandum/Memoranda of Understanding" or "MOU" means an agreement(s) between CalOptima and an external agency(ies), which delineates responsibilities for coordinating care to CalOptima Members.

1.30 "Participating Provider" means an institutional, professional or other Provider of health care services who has entered into a written agreement with CalOptima to provide Covered Services to Members.

1.31 "Participation Status" means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or has a felony conviction (if applicable) as specified in CalOptima's Compliance Program and CalOptima Policies.

1.32 "Preclusion List" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

1.33 "Subcontract" means a contract entered into by Provider with a party that agrees to furnish items and/or services to CalOptima Members, or administrative functions or services related to Provider

fulfilling its obligation to CalOptima under the terms of this Contract if, and to the extent, permitted under this Contract.

1.34 "Subcontractor" means a person or entity who has entered into a Subcontract with Provider for the purposes of filling Provider's obligations to CalOptima under the terms of this Contract. Subcontractors may also be referred to as Downstream Entities.

ARTICLE 2
FUNCTIONS AND DUTIES OF PROVIDER

2.1 Provision of Covered Services.

2.1.1 Provider shall furnish Covered Services identified in Attachment A to eligible Members in the applicable CalOptima Programs. Provider shall furnish such items and services in a manner satisfactory to CalOptima.

2.1.2 Throughout the term of this Contract, and subject to the conditions of the Contract, Provider shall maintain the quantity and quality of its services and personnel in accordance with the requirements of this Contract, to meet Provider's obligation to provide Covered Services hereunder.

2.1.3 In accordance with Section 2.22 of this Contract, Provider and its Subcontractors shall furnish Covered Services to Members under this Contract in the same manner as those services are provided to other patients.

2.2 Licensure. Provider represents and warrants that it has, and shall maintain during the term of this Contract, valid and active Licenses applicable to the Covered Services and for the State in which the Covered Services are rendered.

2.3 Regulatory Approvals. Provider represents and warrants that it has, and shall maintain during the term of this Contract, applicable Medi-Cal and Medicare provider and/or supplier numbers.

2.4 Good Standing. Provider represents it is in good standing with State licensing boards applicable to its business, DHCS, CMS and the DHHS Officer of Inspector General ("OIG"). Provider agrees to furnish CalOptima with any and all correspondence with, and notices from, these agencies of investigations and/or the issuance of criminal, civil and/or administrative sanctions (threatened or imposed) related to licensure, fraud and or abuse (execution of grand jury subpoena, search and seizure warrants, etc.), and/or participation status.

2.5 Geographic Coverage Area. Provider shall serve Members in all areas of Orange County, California.

2.6 Eligibility Verification. Provider shall verify a Member's eligibility for the applicable CalOptima Program benefits upon receiving request for Covered Services. For Members in the Medi-Cal Program with share of cost (SOC) obligations, Provider shall collect SOC in accordance with CalOptima Policies.

2.7 Notices and Citations. Provider shall notify CalOptima in writing of any report or other writing of any State or Federal agency and/or Accreditation Organization that regulates Provider that contains a citation, sanction and/or disapproval of Provider's failure to meet any material requirement of State or Federal law or any material standards of an Accreditation Organization.

2.8 Professional Standards. All Provider Services provided or arranged for under this Contract shall be provided or arranged by duly licensed, certified or otherwise authorized professional personnel in manner that (i) meets the cultural and linguistic requirements of this Contract; (ii) within professionally recognized standards of practice at the time of treatment; (iii) in accordance with the provisions of CalOptima's UM and QMI Programs; and (iv) in accordance with the requirements of State and Federal law and all requirements of this Contract.

2.9 Marketing Requirements. Provider shall comply with CalOptima's marketing guidelines relevant to the pertinent CalOptima Program(s) and applicable laws and regulations.

2.10 Disclosure of Provider Ownership. Provider shall provide CalOptima with the following information, as applicable: (a) names of all officers of Provider's governing board; (b) names of all owners of Provider; (c) names of stockholders owning more than five percent (5%) of the stock issued by Provider; and (d) names of major creditors holding more than five percent (5%) of the debt of Provider. Provider shall complete any disclosure forms required under the CalOptima Programs as requested by CalOptima. Provider shall notify CalOptima immediately of any changes to the information included by Provider in the disclosure forms submitted to CalOptima.

2.11 Not applicable to this Contract.

2.12 CalOptima QMI Program. Provider acknowledges and agrees that CalOptima is accountable for the quality of care furnished to its Members in all settings including services furnished by Provider. Provider agrees, when reasonable and within capability of Provider, that it is subject to the requirements of CalOptima's QMI Program and that it shall participate in QMI Program activities as required by CalOptima. Such activities may include, but are not limited to, the provision of requested data and the participation in assessment and performance audits and projects (including those required by CalOptima's regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members. Provider shall participate in CalOptima's QMI Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for CalOptima Members. Provider shall cooperate with CalOptima and Government Agencies in any complaint, appeal or other review of Provider Services (e.g., medical necessity) and shall accept as final all decisions regarding disputes over Provider Services by CalOptima or such Government Agencies, as applicable, and as required under the applicable CalOptima Program. Provider shall also allow CalOptima to use performance data for quality and reporting purposes including, but not limited to, quality improvement activities and public reporting to consumers, and performance data reporting to regulators as identified in CalOptima Policies.

Provider shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities and public reporting to consumers, as identified in CalOptima policy GG.1638.

2.13 Utilization & Resource Management Program. Provider acknowledges and agrees that CalOptima has implemented and maintains a Utilization & Resource Management Program ("UM Program") that addresses evaluations of medical necessity and processes to review and approve the provision of items and services, including Covered Services, to Members. Provider shall comply with the requirements of the UM Program including, without limitation, those criteria applicable to the Covered Services as described in this Contract.

2.14 CalOptima Oversight. Provider understands and agrees that CalOptima is responsible for the monitoring and oversight of all duties of Provider under this Contract, and that CalOptima has the

authority and responsibility to: (i) implement, maintain and enforce CalOptima Policies governing Provider's duties under this Contract and/or governing CalOptima's oversight role; (ii) conduct audits, inspections and/or investigations in order to oversee Provider's performance of duties described in this Contract; (iii) require Provider to take corrective action if CalOptima or a Government Agency determines that corrective action is needed with regard to any duty under this Contract; and/or (iv) revoke the delegation of any duty, if Provider fails to meet CalOptima standards in the performance of that duty. Provider shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with the laws, accreditation agency standards, and/or CalOptima Policies governing the duties of Provider or the oversight of those duties.

2.15 Transfer of Care. Upon request by a CalOptima Member, Provider shall assist the CalOptima Member in the orderly transfer of such CalOptima Member's medical care. In doing so, Provider shall make available to the new provider of care for the Member, copies of the medical records, patient files, and other pertinent information, including information maintained by any Subcontractor, necessary for efficient medical case management of Member. In no circumstance shall a CalOptima Member be billed for this service.

2.16 Linguistic and Cultural Sensitivity Services. Provider shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. CalOptima will provide cultural competency, sensitivity, and diversity training. Provider shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Provider shall in its policies, administration, and services practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, foster in staff attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Provider shall fully cooperate with CalOptima in the provision of cultural and linguistic services provided by CalOptima for Members receiving services from Provider. Provider shall provide translation of written materials in the threshold languages identified by CalOptima at no higher than the sixth (6^{th}) grade reading level.

2.17 Provision of Interpreters. Provider shall ensure that CalOptima Members are provided with linguistic interpreter services and interpreter services for Members who are deaf and hard of hearing as necessary to ensure effective communication regarding treatment, diagnosis, and medical history or health education pursuant to the requirements in this Contract, CalOptima Policies and Attachment B to this Contract.

Interpreters shall be used where needed and when technical, medical, or treatment information is to be discussed. Provider shall not require a Member to use friends or family as interpreters. However, a family member may be used when the use of the family member or friend: (a) is requested by a Member; (b) will not compromise the effectiveness of service; (c) will not violate a Member's confidentiality; and (d) Member is advised that an interpreter is available at no cost to the Member.

2.18 CalOptima's Compliance Program and Other Guidance. Provider and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("Provider's Agents") shall comply with the requirements of CalOptima's Compliance Program, including CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Plan and Code of Conduct

available to Provider and Provider shall make them available to Provider's Agents. Provider agrees to comply with, and be bound by, any and all MOUs.

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

Provider and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Provider 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.

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

Provider and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

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

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

Provider and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. Provider and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event Provider and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Provider and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2.20 Compliance with Applicable Laws. Provider shall observe and comply with all Federal and State laws and regulations, and requirements established in Federal and/or State programs in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects the Provider's performance under this Contract. Provider understands and agrees that payments made by CalOptima are, in whole or in part, derived from Federal funds, and therefore Provider and any Subcontractor are subject to certain laws that are applicable to individuals and entities receiving Federal funds. Provider agrees to comply with all applicable Federal laws, regulations, reporting requirements and CMS instructions including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and to require any Subcontractor to comply accordingly. Provider agrees to include the requirements of this section in its contracts with any Subcontractor.

2.21 No Discrimination/Harassment (Employees). During the performance of this Contract, Provider and its Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religion, creed, color, national origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender or the use of family and medical care leave and pregnancy disability leave. Provider and Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Provider and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder, (Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and

Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Provider and its Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

2.22 No Discrimination (Member). Neither Provider nor its Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, heath status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, and all other laws regarding privacy and confidentiality.

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute prohibited discrimination: (a) denying any Member any Covered Services or availability of a Provider, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services. Provider and its Subcontractors agree to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Provider and its Subcontractors shall take affirmative action to ensure that all Members are provided Covered Services without discrimination, except where medically necessary. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia. Provider and its Subcontractors shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies.

2.23 Reporting Obligations. In addition to any other reporting obligations under this Contract, Provider shall submit such reports and data relating to services covered under this Contract as are required by CalOptima, including, without limitations, to comply with the requests from Government Agencies to CalOptima. CalOptima shall reimburse Provider for reasonable costs for producing and delivering such reports and data.

2.24 Subcontract Requirements. If permitted by the terms of this Contract, Provider may subcontract for certain functions covered by this Contract, subject to the requirements of this Contract.

Subcontracts shall not terminate the legal liability of Provider under this Contract. Provider must ensure that all Subcontracts are in writing and include any and all provisions required by this Contract or applicable Government Programs to be incorporated into Subcontracts. Provider shall make all Subcontracts available to CalOptima or its regulators upon request. Provider is required to inform CalOptima of the name and business addresses of all Subcontractors. Additionally, Provider shall require that all Subcontracts relating to the provision of Covered Services include, without limitation, the following provisions:

2.24.1 An agreement to make all books and records relative to the provision of and reimbursement for Covered Services furnished by Subcontractor to Provider available at all reasonable times for inspection, examination or copying by CalOptima or duly authorized representatives of the Government Agencies in accordance with Government Contract requirements.

2.24.2 An agreement to maintain such books and records (a) in accordance with the general standards applicable to such books and records and any record requirements in this Contract and CalOptima Policies; (b) at the Subcontractor's place of business or at such other mutually agreeable location in California.

2.24.3 An agreement for the establishment and maintenance of and access to records as set forth in this Contract.

2.24.4 An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in the same manner as those services are provided to other patients.

2.24.5 An agreement to comply with all provisions of this Contract and applicable law with respect to providing and paying for Emergency Services.

2.24.6 An agreement that Subcontractors shall notify Provider of any investigations into Subcontractors' professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

2.24.7 An agreement to comply with CalOptima's Compliance Program.

2.24.8 An agreement to comply with Member financial and hold harmless protections as set forth in this Contract.

2.25 Fraud and Abuse Reporting. Provider shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Provider, whether by Provider, Provider's employees, Subcontractors, and/or Members within five (5) working days of the date when Provider first becomes aware of or is on notice of such activity.

2.26 Participation Status. Provider shall have Policies and Procedures to verify the Participation Status of Provider's Agents. In addition, Provider attests and agrees as follows:

2.26.1 Provider and Provider's Agents shall meet CalOptima's Participation Status requirements during the term of this Contract.

2.26.2 Provider shall immediately disclose to CalOptima, including, but not limited to, any pending investigation involving, or any determination of, suspension, exclusion or

debarment of Provider or Provider's Agents occurring and/or discovered during the term of this Contract.

2.26.3 Provider shall take immediate action to remove any employee of Provider that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to CalOptima Members which may include but is not limited to adverse decisions and licensure issues.

2.26.4 Provider shall include the obligations of this Section in its Subcontracts.

2.26.5 CalOptima shall not make payment for a healthcare item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Provider shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

2.27 Credentialing and Recredentialing. Prior to providing any Covered Services under, and throughout the duration of, this Contract, Provider, and all Subcontractors, shall be credentialed and periodically recredentialed by CalOptima in the manner and to the extent required by CalOptima Policy.

2.28 Physical Access for Members. Provider's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

2.29 Smoke Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Provider certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. Provider further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

2.30 CLIA Laboratories. Provider shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

2.31 Member Rights. Provider shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policy, are fully respected and observed.

2.32 Electronic Transactions. Provider shall use best efforts to participate in the exchange of electronic transactions with CalOptima, including but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic prior authorization transactions in accordance with CalOptima Policy and Procedure.

2.33 Advanced Directives. Provider shall maintain written Policies and Procedures related to Advanced Directives in compliance with State and Federal laws and regulations. Provider shall document patient records with respect to the existence of an Advanced Directive in accordance with applicable law. Provider shall not discriminate against any Member on the basis of that Member's Advanced Directive status. Nothing in this Contract shall be interpreted to require a Member to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

2.34 Not applicable to this Contract.

2.35 Not applicable to this Contract.

2.36 Provider Terminations. In the event that a Participating Provider is terminated or leaves Provider, Provider shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS, Provider shall ensure that there is no disruption in services provided to the CalOptima Member.

2.37 Government Claims Act. Provider shall ensure that Provider and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et seq.), including, but not limited to Government Code sections 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

2.38 Certification of Document and Data Submissions. All data, information, and documentation provided by Provider to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Provider's letterhead sign by the Provider's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

2.39 Community Supports.

2.39.1 Community Supports Provider Requirements.

2.39.1.1 If a State-level enrollment pathway exists for the Community Supports Provider, the Community Supports Provider shall enroll in the Medi-Cal program pursuant to relevant APLs, including APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment. If APL 19-004 does not apply to the Community Supports Provider, the Community Supports Provider will comply with CalOptima's process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering

services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

2.39.1.2 The Community Supports Provider shall have experience and/or training in the provision of the Community Supports being offered.

2.39.1.3 The Community Supports Provider shall have the capacity to provide the Community Supports in a culturally and linguistically competent manner, as demonstrated by a successful history of providing such services, training or other factors identified by CalOptima.

2.39.1.4 Subject to all applicable requirements set forth in this Contract (including but not limited to, subcontracting requirements) and CalOptima's prior written approval, if the Community Supports Provider subcontracts with other entities to administer its function of Community Supports, the Community Supports, the Community Supports Provider shall ensure agreements with each entity bind each entity to applicable terms and conditions set forth in Section 2.39 and Attachment A of this Contract and CalOptima Policies. Notwithstanding and subcontracting arrangements, Community Supports Provider shall remain responsible and accountable for any subcontracted Community Supports Functions.

2.39.2 Delivery of Community Supports. Community Supports Provider shall deliver contracted Community Supports in accordance with the DHCS service definitions and requirements, CalOptima Policies, including but not limited to, CalOptima Policy GG.1355: Community Supports, and this Contract.

2.39.2.1 Community Supports Provider shall maintain staffing that allows for timely, high-quality service delivery of the Community Supports that it is contracted to provide.

2.39.2.2 Community Supports Provider shall:

a. Accept and act upon Member referrals from CalOptima or Health Network for authorized Community Supports, unless the Community Supports Provider is at pre-determined capacity;
b. Conduct outreach to the referred Member for authorized Community Supports Providers as soon as possible, including by making best efforts to conduct initial outreach within 24 hours of assignment, if applicable;
c. Be responsive to incoming calls or other outreach from Members, including by maintaining a phone line that is staffed or able to record voicemail 24 hours a day, 7 days a week;
d. Coordinate with other providers in the Member's care team, including ECM Providers, other Community Supports providers, CalOptima and Health Networks;
e. Comply with cultural competency and linguistic requirements required by this Contract, CalOptima Policies and federal, State and local laws;
f. Comply with non-discrimination requirements set forth in this Contract and State and Federal law.

2.39.3 When federal law requires authorization for data sharing, Community Supports Provider shall obtain and/or document such authorization from each assigned Member, including sharing of protected health information (PHI), and shall confirm it has obtained such authorization to CalOptima. Member authorization for Community Supports-related data sharing is not required for the Community Supports Provider to initiate delivery of Community Supports unless such authorization is required by federal law. Community Supports Provider will be reimbursed only for Community Supports services that are authorized by CalOptima or Health Network. In the event of a Member requesting Community Supports services that are not yet authorized by CalOptima or a Health Network, Community Supports Provider shall send prior authorization request(s) to CalOptima for a CalOptima Direct Member or the Member's assigned Health Network, as applicable.

2.39.4 If a Community Supports is discontinued for any reason, Community Supports Provider shall support transition planning for the Member into other programs or services that meet their needs.

2.39.5 Community Supports Provider is encouraged to identify additional Community Supports the Member may benefit from and send any additional request(s) for Community Supports to CalOptima or Health Network for authorization.

2.39.6 Payment of Community Supports. Community Supports Provider shall record, generate, and send a claim or invoice to CalOptima for Community Supports rendered. If Community Supports Provider submits claims, Community Supports Provider shall submit claims to CalOptima using specifications based Medi-Cal national standards and code sets defined by DHCS.

2.39.6.1 In the event Community Supports Provider is unable to submit claims to CalOptima for Community Supports-related services using specifications based on national standards or DHCS-defined standard specifications and code sets, Community Supports Provider shall submit invoices with minimum necessary data elements defined by DHCS, which includes information about the Member, the Community Supports services rendered, and Community Supports Providers' information to support appropriate reimbursement by CalOptima, that will allow CalOptima to convert Community Supports invoice information into DHCS-defined standard specifications and code sets for submission to DHCS.

2.39.6.2 Community Supports Provider shall not receive payment from CalOptima for the provision of any Community Supports services not authorized by CalOptima or Health Network.

2.39.6.3 CalOptima will provide expedited payments for urgent Community Supports (e.g., Recuperative Care services for a Member who no longer requires hospitalization, but still needs to heal from an injury or illness, including behavioral health conditions, and whose condition would be exacerbated by an unstable living environment), pursuant to its Contract with DHCS and any other related DHCS guidance.

2.39.7 Community Supports Provider must have a system in place to accept payment from CalOptima for Community Supports rendered. CalOptima shall pay 90 percent of all clean

claims and invoices within 30 days of receipt and 99 percent of clean claims and invoices within 90 days of receipt.

2.39.8 Data Sharing to Support Community Supports. As part of the referral process, CalOptima will ensure Community Supports Provider has access to:

2.39.8.1 Demographic and administrative information confirming the referred Member's eligibility for the requested service;

2.39.8.2 Appropriate administrative, clinical, and social service information the Community Supports Provider might need in order to effectively provide the requested service; and

2.39.8.3 Billing information necessary to support the Community Supports Provider's ability to submit invoices to CalOptima.

2.39.9 Quality and Oversight. Community Supports Provider acknowledges that CalOptima will conduct oversight of its delivery of Community Supports to ensure the quality of services rendered and ongoing compliance with all legal and contractual obligations both CalOptima and the Community Supports Provider have, including but not limited to, required reporting, audits, and corrective actions, among other oversight activities.

ARTICLE 3
FUNCTIONS AND DUTIES OF CALOPTIMA

3.1 Payment. CalOptima shall pay Provider for Covered Services provided to CalOptima Members. Provider agrees to accept the compensation set forth in Attachment C as payment in full from CalOptima for such Covered Services. Upon submission of a Clean Claim, CalOptima shall pay Provider pursuant to CalOptima Policies and Attachment C. Notwithstanding the foregoing, Provider may also collect other amounts (e.g., copayments, deductibles, OHC and/or third party liability payments) where expressly authorized to do so under the CalOptima Program(s) and applicable law. Provider agrees that Members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the provider will (A) accept the plan payment as payment in full, or (B) bill the appropriate State source as required at 42 CFR §422.504(g)(1)(iii).

3.2 Service Authorization. CalOptima shall provide a written authorization process for Covered Services pursuant to CalOptima Policies.

3.3 Limitations of CalOptima's Payment Obligations. Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Provider any amounts shall be subject to CalOptima's receipt of the funding from the Federal and/or State governments.

ARTICLE 4
PAYMENT PROCEDURES

4.1 Billing and Claims Submission. Provider shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

4.2 Prompt Payment. CalOptima shall make payments to Provider in the time and manner set forth in CalOptima Policies related to the CalOptima Programs and/or this Contract. Additional procedures related to claims processing and payment are set forth in the attached CalOptima Program Addenda.

4.3 Claim Completion and Accuracy. Provider shall be responsible for the completion and accuracy of all Claims submitted whether on paper forms or electronically including claims submitted for the Provider by other parties. Use of a billing agent does not abrogate Provider's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Provider acknowledges that Provider remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

4.4 Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Provider notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.

4.5 COB. Provider shall coordinate benefits with other programs or entitlements recognizing where OHC is primary coverage in accordance with CalOptima Program requirements. Provider acknowledges that Medi-Cal is the payor of last resort.

4.6 (This section left intentionally blank)

4.7 Member Financial Protections. Provider and its Subcontractors shall comply with Member financial protections as follows:

4.7.1 Provider agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Provider for any amounts which are owed by, or are the obligation of, CalOptima.

4.7.2 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or Provider's insolvency, or breach of this contract by CalOptima, shall Provider, or any of its Subcontractors, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Provider may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

4.7.3 This provision does not prohibit Provider or its Subcontractors from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

4.7.4 Upon receiving notice of Provider invoicing or balance billing a Member for the difference between the Provider's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Provider or take other action as provided in this Contract.

4.7.5 This section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause

giving rise to termination, and shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the Provider and its Subcontractors. Language to ensure the foregoing shall be included in all of Provider's Subcontracts related to provision of Covered Services to CalOptima Members.

4.8 Overpayments and CalOptima Right to Recover. Provider has an obligation to report any overpayment identified by Provider, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Provider, or of receipt of notice of an overpayment identified by CalOptima. Provider acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Provider, CalOptima shall have the right to recover such amounts from Provider by recoupment or offset from current or future amounts due from CalOptima to Provider, after giving Provider notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Provider to CalOptima, including, but not limited to, amounts due because of:

4.8.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this contract.

4.8.2 Payments made for services provided to a Member that is subsequently determined to have not be eligible on the date of service.

4.8.3 Unpaid Conlan reimbursements owed by provider to a Member.

4.8.4 Payments made for services provided by a Provider that has entered into a private contract with a Medicare beneficiary for Covered Services.

ARTICLE 5
INSURANCE AND INDEMNIFICATION

5.1 Indemnification. Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, of any functions, duties or obligations of such party under this Contract. Neither termination of this Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.2 Provider Professional Liability. Provider, at its sole cost and expense, shall ensure that it and Subcontractors providing professional services under this Contract shall maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts which are at least equal to the community minimum amounts in Orange County, California, for the specialty or type of service which Provider provides, with a minimum of $1,000,000 per incident/$3,000,000 aggregate per year.

5.3 Provider Commercial General Liability ("CGL")/Automobile Liability. Provider at its sole cost and expense shall maintain such policies of commercial general liability and automobile liability insurance and other insurance as shall be necessary to insure it and its business addresses, customers (including Members), 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 furnishing of any Covered Services hereunder, b) the use of any property of the Provider, and c) activities performed in connection with the Contract, with minimum coverage of $1,000,000 per incident/$3,000,000 aggregate per year.

5.4 Workers Compensation Insurance. Provider at its sole cost and expense shall maintain workers compensation insurance within the limits established and required by the State of California and employers liability insurance with minimum limits of liability of $1,000,000 per occurrence/$1,000,000 aggregate per year.

5.5 Insurer Ratings. All above insurance shall be provided by an insurer:

5.5.1 rated by Best's with a rating of B or better; and

5.5.2 "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI) or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

5.6 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.

5.7 Cancellation or Material Change. The Provider 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 Contract.

5.8 Certificates of Insurance. Prior to execution of this Contract, Provider shall provide Certificates of Insurance 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 coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

ARTICLE 6
RECORDS, AUDITS AND REPORTS

6.1 Access to and Audit of Contract Records. For the purpose of review of items and services furnished under the terms of this Contract and duplication of any books and records, Provider and its Subcontractors shall allow CalOptima, its regulators and/or their duly authorized agents and representatives access to said books and records, including medical records, contracts, documents, electronic systems for the purpose of direct physical examination of the records by CalOptima or its regulators and/or their duly authorized agents and representatives at the Provider's premises. Provider shall be given advance notice of such visit in accordance with CalOptima Policies. Such access shall include the right to directly observe all aspects of Provider's operations and to inspect, audit and reproduce all records and materials and to verify Claims and reports required according to the provisions of this Contract. Provider shall maintain records in chronological sequence, and in an immediately retrievable form in accordance with the laws and regulations applicable to such record keeping. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Provider at any time. Upon resolution of a full investigation of fraud, DHCS

reserves the right to suspend or terminate the Provider and its Subcontractors from participation in the Medi-Cal program; seek recovery of payments made to the Provider; impose other sanctions provided under the State Plan, and Provider's contract may be terminated due to fraud.

6.2 Medical Records. Provider and its Subcontractors shall establish and maintain for each Member who has obtained Covered Services, medical records which are organized in a manner which contain such demographic and clinical information as is necessary to provide and ensure accurate and timely documentation as to the medical problems and Covered Services provided to the Member. Such medical records shall be consistent with State and Federal laws and CalOptima Program requirements and shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Provider. Such medical records shall be in such a form as to allow trained health professionals, other than the Provider, to readily determine the nature and extent of the Member's medical problem and the services provided, and to permit peer review of the care furnished to the Member.

6.3 Records Retention. The Provider shall maintain books and records in accordance with the time and manner requirements set forth in Federal and State laws and CalOptima Programs as identified in the CalOptima Program Addenda to this Contract. Where the Provider furnishes Covered Services to a Member in more than one CalOptima Program with different record retention periods, then the greater of the record retention requirements shall apply.

6.4 Audit, Review and/or Duplication. Audit, review and/or duplication of data or records shall occur within regular business hours, and shall be subject to Federal and State laws concerning confidentially and ownership of records. Provider shall pay all duplication and mailing costs associated with such audits.

6.5 Confidentiality of Member Information. Provider agrees to comply with applicable Federal and State laws and regulations governing the confidentiality of Member medical and other information. Provider further agrees:

6.5.1 Health Insurance Portability and Accountability Act (HIPAA). Provider shall comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements. Provider shall comply with HIPAA requirements as currently established in CalOptima Policies. Provider shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

6.5.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. For the purpose of this Contract, Provider shall protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.5.3 Declaration of Confidentiality. If Provider and its Subcontractors have access to computer files or any data confidential by statute, including identification of eligible members, Provider and Subcontractors agree to sign a declaration of confidentiality in accordance with the applicable Government Contract and in a form acceptable to CalOptima and DHCS, DMHC (MRMIB) and/or CMS, as applicable.

6.6 Data Submission. Provider shall submit to CalOptima complete, accurate, reasonable, and timely provider data, encounter date, and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

ARTICLE 7
TERM AND TERMINATION

7.1 Term. The term of this Contract shall become effective on the Effective Date through June 30, 2022. This Contract shall then automatically extend for additional one-year terms (July 1st through June 30th) upon formal approval by the CalOptima Board of Directors, unless earlier terminated by either party as provided for in this Contract.

7.2 Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Provider or any Subcontractor (a) has repeatedly and inappropriately withheld Covered Services to a CalOptima Member(s), (b) has failed to perform its contracted duties and responsibilities in a timely and proper manner including, without limitation, service procedures and standards identified in this Contract, (c) has committed acts that discriminate against CalOptima Members on the basis of their health status or requirements for health care services; (d) has not provided Covered Services in the scope or manner required under the provisions of this Contract; (e) has engaged in prohibited marketing activities; (f) has failed to comply with CalOptima's Compliance Program, including Participation Status requirements; (g) has committed fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; or (h) has materially breached any covenant, condition, or term of this Contract. A termination as described above shall be referred to herein as "Termination for Default." In the event of a Termination for Default, CalOptima shall give Provider prior written notice of its intent to terminate with a thirty (30)-day cure period if the Termination for Default is curable, in the sole discretion of CalOptima. In the event the default is not cured within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this clause are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. The Provider shall not be relieved of its liability to CalOptima for damages sustained by virtue of breach of the Contract by the Provider or any Subcontractor.

7.3 Immediate Termination. CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice: (i) the suspension or revocation of any license, certification or accreditation required by Provider and/or Provider Agents; (ii) the determination by CalOptima that the health, safety, or welfare of Members is jeopardized by continuation of this Contract; (iii) the imposition of sanctions or disciplinary action against Provider or against Provider Agents in their capacities with the Provider by any Federal or State licensing agency; (iv) termination or non-renewal of any Government Contract; (v) the withdrawal of DHHS's approval of the waiver granted to the CalOptima under Section 1915(b) of the Social Security Act. If CalOptima receives notice of termination from any of the Government Agencies or termination of the Section 1915(b) waiver, CalOptima shall immediately transmit such notice to Provider.

7.4 Termination for Provider Insolvency. If the Provider and/or any of its Subcontractors becomes insolvent, the Provider shall immediately so advise CalOptima, and CalOptima shall have, at its sole option, the right to terminate the Contract immediately. In the event of the filing of a petition for bankruptcy by or against the Provider or a principal Subcontractor, the Provider shall assure

that all tasks related to the Contract or the Subcontract are performed in accordance with the terms of the Contract.

7.5 Modifications or Termination to Comply with Law. CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by Government Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify Provider in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements, and Provider shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

7.6 Termination Without Cause. Either party may terminate this Contract, without cause, upon ninety (90) days prior written notice to the other party as provided herein.

7.7 Rate Adjustments. The payment rates may be adjusted by CalOptima during the Contract period to reflect implementation of Federal or State laws or regulations, changes in the State budget, the Government Contract(s) or the Government Agencies' policies, and/or changes in Covered Services. If the Government Agency(ies) has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Provider as soon as practicable.

7.8 Obligations Upon Termination. Upon termination of this Contract, it is understood and agreed that Provider shall continue to provide authorized Covered Services to Members who retain eligibility and who are under the care of Provider at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. Payment for services under this paragraph shall be at the contracted rates. Prior to the termination or expiration of this Contract, and upon request by CalOptima or one of its regulatory agencies to assist in the orderly transfer of Members' medical care, Provider shall make available to CalOptima and/or such regulatory agency, copies of any pertinent information, including information maintained by Provider and any Subcontractor necessary for efficient case management of Members. Costs of reproduction shall be borne by CalOptima or the government agency, as applicable. For purposes of this section only, "under the care of Provider" shall mean that a Member has an authorization from CalOptima to receive services from the Provider issued prior to the Termination, all of the services authorized under that authorization have not yet been completed, and the time period covered by the authorization has not yet expired.

7.9 Approval By and Notice to Government Agencies. Provider acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of applicable Federal and/or State agencies. CalOptima and Provider shall notify the Federal and/or State agencies of amendments to, or termination of, this Contract. Notice shall be given by first-class mail, postage prepaid to the attention of the State or Federal contracting officer for the pertinent CalOptima Program. Provider acknowledges and agrees that any amendments or modifications shall be consistent with requirements relating to submission to such Federal and/or State agency for approval.

ARTICLE 8
GRIEVANCES AND APPEALS

8.1 Provider Grievances. CalOptima has established a fast and cost-effective complaint system for provider complaints, grievances and appeals. Provider shall have access to this system for any

issues arising under this Contract, as provided in CalOptima Policies related to the applicable CalOptima Program(s). Provider complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract shall be resolved through such system.

8.2 Member Grievances and Appeals. Member grievances, complaints, and/or appeals shall be resolved in accordance with Federal and/or State laws, regulations and Government Guidance and as set forth in CalOptima Policies relating to the applicable CalOptima Program. Provider agrees to cooperate in the investigation of the issues and be bound by CalOptima's grievance decisions and, if applicable, State and/or Federal hearing decisions or any subsequent appeals.

ARTICLE 9
GENERAL PROVISIONS

9.1 Assignment and Assumption. Provider acknowledges and agrees that a primary goal of CalOptima is to ensure the provision of quality healthcare services to CalOptima Members and that CalOptima and Provider have entered into this Contract for the benefit of CalOptima Members. Accordingly, CalOptima retains the rights set forth in this Section. Except as specifically permitted hereunder, this Contract is not assignable by the Provider, either in whole or in part, without the prior written consent of CalOptima, provided that CalOptima's consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract, assignment includes, without limitation, (a) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions), (b) the change of more than twenty-five percent (25%) of the directors or trustees of Provider, (c) the merger, reorganization, or consolidation of Provider with another entity with respect to which Provider is not the surviving entity, and/or (d) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

9.2 Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Provider and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder.

9.3 Force Majeure. Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

9.4 Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima Programs and all contractual obligations of CalOptima. Provider shall bring any and all legal proceedings against CalOptima under this Contract in California State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceedings shall be brought in the Central District Court of California.

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

9.6 Independent Contractor Relationship. CalOptima and Provider agree that the Provider and any agents or employees of the Provider in performance of this Contract shall act in an independent capacity and not as officers or employees of CalOptima. Provider's relationship with CalOptima in the performance of this Contract is that of an independent contractor. Provider's personnel performing services under this Contract shall be at all times under Provider's exclusive direction and control and shall be employees of Provider and not employees of CalOptima. Provider shall pay all wages, salaries and other amounts due its employees in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, CalOptima and the Provider hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

9.8 No Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

9.9 Notices. Any notice required to be given pursuant to the terms and provisions of this Contract, unless otherwise indicated herein, shall be in writing and shall be sent by Certified or Registered mail, return receipt requested, postage prepaid to the address set out below. Notice shall be deemed given seventy-two (72) hours after mailing.

If to CalOptima:

CalOptima
Director of Contracting
505 City Parkway West
Orange, CA 92868

If to Provider:

_____
Name

_____
Title

_____
Address

_____

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

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

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

9.12 Regulatory Approval. Notwithstanding any other provision of this Contract, the effectiveness of this Contract, amendments thereto, and assignments thereof, is subject to the approval of applicable Governmental Agencies and the conditions imposed by such agencies.

9.13 Authority to Execute. The persons executing this Contract on behalf of the parties warrant that they are duly authorized to execute this Contract, and that by executing this Contract, the parties are formally bound.

9.14 Severability. In the event any provision of this Contract is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, by any regulation duly promulgated by the United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

ARTICLE 10
EXECUTION

10.1 Subject to the State of California and United States providing funding for the term of this Contract and for the purposes with respect to which it is entered into, and execution of the Government Contracts and the approval of the Contract by the Government Agencies, this Contract shall become effective January 1, 2022 (the "Effective Date").

IN WITNESS WHEREOF, the parties have executed this Contract as follows:

Provider	**CalOptima**
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name
_____	Chief Operating Officer
Title	Title
_____	_____
Date	Date

ATTACHMENT A

COVERED SERVICES

ARTICLE 1

CALOPTIMA PROGRAMS

1.1 CalOptima Medi-Cal Program. Provider shall furnish Community Supports Covered Services under the CalOptima Medi-Cal Program and to CalOptima's eligible Medi-Cal Members.

ARTICLE 2
SERVICES

Scope of Covered Services. "Covered Services" as referred to in this Contract means XXXXXXXX described below.

Recuperative Care (Medical Respite)

2.1 Description/Overview

2.1.1 Recuperative care, also referred to as medical respite care, is short-term residential care for Members who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. An extended stay in a recovery care setting allows Members to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

2.1.2 At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the Member's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on Member needs, the service may also include:

2.1.2.1 Limited or short-term assistance with Instrumental Activities of Daily Living (IADLs) &/or Activities of Daily Living ADLs

2.1.2.2 Coordination of transportation to post-discharge appointments

2.1.2.3 Connection to any other on-going services a Member may require including mental health and substance use disorder services

2.1.2.4 Support in accessing benefits and housing

2.1.2.5 Gaining stability with case management relationships and programs

2.1.3 Recuperative care is primarily used for those Members who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment; but are not otherwise ill enough to be in a hospital.

2.1.4 The services provided to a Member while in Recuperative Care shall not replace or be duplicative of the services provided to members utilizing the ECM program. Recuperative Care may be utilized in conjunction with other housing Community Supports. Whenever possible, other housing Community Supports shall be provided to members onsite in the Recuperative Care facility. When enrolled in ECM, Community Supports shall be managed in coordination with ECM providers.

2.1.5 The services provided shall utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

2.2 Eligibility (Population Subset)

2.2.1 Members who are at risk of hospitalization or are post-hospitalization, and

2.2.2 Members who live alone with no formal supports; or

2.2.3 Members who face housing insecurity or have housing that would jeopardize their health and safety without modification.

2.3 Restrictions and Limitations

2.3.1 Recuperative Care/medical respite is an allowable Community Supports service if it is 1) necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health interventions, 2) not more than 90 days in continuous duration, and 3) does not include funding for building modification or building rehabilitation.

2.3.2 Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.4 Licensing/Allowable Providers

2.4.1 Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers CalOptima may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

2.4.1.1 Interim housing facilities with additional on-site support

2.4.1.2 Shelter beds with additional on-site support

2.4.1.3 Converted homes with additional on-site support

2.4.1.4 County directly operated or contracted Recuperative Care facilities

2.4.2 Facilities are unlicensed. CalOptima shall apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. CalOptima can adopt

or adapt local or national standards for Recuperative Care or interim housing. CalOptima shall monitor the provision of all the services included above.

2.4.3 Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program pursuant to relevant DHCS All Plan Letters (APLs), including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Housing Deposits

2.1 Description/Overview

2.1.1 Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute payment for room and board, such as:

2.1.1.1 Security deposits required to obtain a lease on an apartment or home.

2.1.1.2 Set-up fees/deposits for utilities or service access and utility arrearages.

2.1.1.3 First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.

2.1.1.4 First month's and last month's rent as required by landlord for occupancy.

2.1.1.5 Services necessary for the Member's health and safety, such as pest eradication and one-time cleaning prior to occupancy.

2.1.1.6 Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve a Members' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the Member upon move-in to the home.

2.1.2 The services provided shall be based on individualized assessment of needs and documented in the individualized housing support plan. Members may require and access a subset of the services listed above.

2.1.3 The services provided shall utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

2.1.4 Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

2.2 Eligibility (Population Subset)

2.2.1 Any Member who received Housing Transition/Navigation Services Community Supports.

2.2.2 Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable Members with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

2.2.3 Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those

exiting institutions but not including any limits on the number of days in the institution) and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals.

2.3 Restrictions and Limitations

2.3.1 Housing Deposits are available once in a Member's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if Member has previously received services.

2.3.2 These services must be identified as reasonable and necessary in the Member's individualized housing support plan and are available only when the Member is unable to meet such expense.

2.3.3 Members must also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

2.3.4 Members may not be receiving duplicative support from other State, local or federally funded programs, which shall always be considered first, before using Medi-Cal funding.

2.4 Licensing/Allowable Providers

2.4.1 Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner.

2.4.2 The entity that is coordinating a Member's Housing Transition Navigation Services, or the CalOptima case manager, care coordinator or housing navigator may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services.

2.4.3 Providers must have demonstrated or verifiable experience and expertise with providing these unique services.

2.4.4 Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment (APL 19-004). If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Housing Transition Navigation Services

2.1 Description/Overview

2.1.1 Housing Transition Navigation services assist Members with obtaining housing and include:

2.1.1.1 Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on the Member's housing needs, potential Housing Transition barriers, and identification of housing retention barriers.

2.1.1.2 Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the Member's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.

2.1.1.3 Searching for housing and presenting options.

2.1.1.4 Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

2.1.1.5 Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.

2.1.1.6 Identifying and securing available resources to assist with subsidizing rent (such as Section 8, state and local assistance programs etc.) and matching available rental subsidy resources to Members.

2.1.1.7 Identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses. Actual payment of these Housing Deposits and move-in expenses is a separate Community Supports under Housing Deposits.

2.1.1.8 Assisting with requests for reasonable accommodation, if necessary as related to expenses incurred by the housing navigator supporting the Member moving into the home.

2.1.1.9 Educating and engaging with landlords.

2.1.1.10 Ensuring that the living environment is safe and ready for move-in.

2.1.1.11 Communicating and advocating on behalf of the Member with landlords.

2.1.1.12 Assisting with arranging for and supporting the details of the move.

2.1.1.13 Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized. The services associated with the crisis plan are a separate Community Supports under Housing Tenancy and Sustaining Services.

2.1.1.14 Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.

2.1.1.15 Identifying and coordinating, environmental modifications to install necessary accommodations for accessibility.

2.1.2 The services provided shall be based on individualized assessment of needs and documented in the individualized housing support plan. Members may only require and access a subset of the services listed above.

2.1.3 The services provided shall utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. Examples of best practices include Housing First Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

2.1.4 The services may involve additional coordination with other entities to ensure the Member has access to supports needed for successful tenancy. These entities may include County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; Sheriff's Department and Probation Officers, as applicable and to the extent possible; local legal service programs, community-based organizations housing providers, local housing agencies and housing development agencies. For Members who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Some housing assistance (including recovery residences and emergency assistance or rental subsidies for Full Service Partnership Members) is also funded by county behavioral health agencies, and CalOptima and their contracted Community Supports Providers shall expect to coordinate access to these housing resources through county behavioral health when appropriate.

2.1.5 Services should be seamless for Members experiencing homelessness entering the Housing Transition Navigation Services to Community Supports.

2.1.6 Services do not include the provision of room and board or payment of rental costs. Coordination with local entities is crucial to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

2.2 Eligibility (Population Subset)

2.2.1 Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable Members with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or

requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

2.2.2 Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

2.2.3 Members who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

2.2.3.1 A Member or family who:

2.2.3.1.1 Has an annual income below 30 percent of median family income for the area, as determined by HUD;

2.2.3.1.2 Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in section 2.2.3 of the "Homeless" definition in this section; and

2.2.3.1.3 Meets one of the following conditions:

a. Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
b. Is living in the home of another because of economic hardship;
c. Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

2.2.3.1.4 Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income Members;

2.2.3.1.5 Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

2.2.3.1.6 Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

2.2.3.1.7 Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

2.2.3.2 A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

2.2.3.3 A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

2.2.4 Members who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

2.2.4.1 Have one or more serious chronic conditions;

2.2.4.2 Have a Serious Mental Illness;

2.2.4.3 Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder; or

2.2.4.4 Have a Serious Emotional Disturbance (children and adolescents);

2.2.4.5 Are receiving Enhanced Care Management; or

2.2.4.6 Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence..

2.3 Restrictions and Limitations

2.3.1 Housing Transition/Navigation services must be identified as reasonable and necessary in the Member's individualized housing support plan. The service duration can be as long as necessary.

2.3.2 Members may not be receiving duplicative support from other State, local tax or federally funded programs, which shall always be considered first, before using Medi-Cal funding.

2.4 Licensing/Allowable Providers

2.4.1 Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers CalOptima may choose to contract with, but it is not an exhaustive list of providers who may offer the services. Providers must have demonstrated experience with providing housing-related services and supports and may include providers such as:

2.4.1.1 Vocational services agencies;

2.4.1.2 Providers of services for Members experiencing homelessness;

2.4.1.3 Life skills training and education providers;

2.4.1.4 County agencies;

2.4.1.5 Public hospital systems;

2.4.1.6 Mental health or substance use disorder treatment providers, including county behavioral health agencies;

2.4.1.7 Social services agencies;

2.4.1.8 Affordable housing providers;

2.4.1.9 Supportive housing providers; and

2.4.1.10 Federally qualified health centers and rural health clinics.

2.4.2 Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

2.4.3 Members who meet the eligibility requirements for Housing Transition/Navigation services shall also be assessed for ECM and Housing and Tenancy Support Services. When enrolled in ECM, Community Supports shall be managed in coordination with ECM providers. When Members receive more than one of these services, CalOptima shall ensure services are coordinated by an ECM provider whenever possible to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management. One exception to this is for benefits advocacy, which may require providers with a specialized skill set.

2.4.4 If the CalOptima case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experience working with Members experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations.

Housing Tenancy and Sustaining Services

2.1 Description/Overview

2.1.1 This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. Services include:

2.1.1.1 Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.

2.1.1.2 Education and training on the role, rights and responsibilities of the tenant and landlord.

2.1.1.3 Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.

2.1.1.4 Coordination with the landlord and case management provider to address identified issues that could impact housing stability.

2.1.1.5 Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the Member owes back rent or payment for damage to the unit.

2.1.1.6 Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.

2.1.1.7 Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.

2.1.1.8 Assistance with the annual housing recertification process.

2.1.1.9 Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

2.1.1.10 Continuing assistance with lease compliance, including ongoing support with activities related to household management.

2.1.1.11 Health and safety visits, including unit habitability inspections. This does not include housing quality inspections.

2.1.1.12 Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

2.1.1.13 Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

2.1.2 The services provided shall be based on individualized assessment of needs and documented in the individualized housing support plan. Members may only require and access a subset of the services listed above.

2.1.3 The services provided shall utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

2.1.4 The services may involve coordination with other entities to ensure the Member has access to supports needed to maintain successful tenancy. Final program guidelines shall adopt, as a standard, the demonstrated need to ensure seamless service to Members experiencing homelessness entering the Housing Tenancy and Sustaining Services Community Supports.

2.1.5 Services do not include the provision of room and board or payment of rental costs.

2.2 Eligibility (Population Subset)

2.2.1 Any Member who received Housing Transition/Navigation Services Community Supports.

2.2.2 Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable Members with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

2.2.3 Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

2.2.4 Members who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

2.2.4.1 A Member or family who:

2.2.4.1.1 Has an annual income below 30 percent of median family income for the area, as determined by HUD;

2.2.4.1.2 Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately

available to prevent them from moving to an emergency shelter or another place described in section 2.2.3 of the "Homeless" definition in this section; and

2.2.4.1.3 Meets one of the following conditions:

a. Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
b. Is living in the home of another because of economic hardship;
c. Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

2.2.4.1.4 Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income Members;

2.2.4.1.5 Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

2.2.4.1.6 Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

2.2.4.1.7 Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

2.2.4.2 A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

2.2.4.3 A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

2.2.5 Members who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

2.2.5.1 Have one or more serious chronic conditions;

2.2.5.2 Have a Serious Mental Illness;

2.2.5.3 Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder, or

2.2.5.4 Have a Serious Emotional Disturbance (children and adolescents);

2.2.5.5 Are receiving Enhanced Care Management; or

2.2.5.6 Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence. .

2.3 Restrictions and Limitations

2.3.1 These services are available from the initiation of services through the time when the Member's housing support plan determines they are no longer needed. They are only available for a single duration in the Member's lifetime. Housing Tenancy and Sustaining Services can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. CalOptima is expected to make a good faith effort to review information available to them to determine if Member has previously received services. The service duration can be as long as necessary.

2.3.2 These services must be identified as reasonable and necessary in the Member's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.

2.3.3 Many Members will have also received Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service but it is not a prerequisite for eligibility.

2.3.4 Members may not be receiving duplicative support from other State, local or federally funded programs, which shall always be considered first, before using Medi-Cal funding.

2.4. Licensing/Allowable Providers

2.4.1 Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers CalOptima may choose to contract with, but it is not an exhaustive list of providers who may offer the services. Providers must have demonstrated or verifiable experience or expertise with providing housing-related services and supports and may include providers such as:

2.4.1.1 Vocational services agencies

2.4.1.2 Providers of services for Members experiencing homelessness

2.4.1.3 Life skills training and education providers

2.4.1.4 County agencies

2.4.1.5 Public hospital systems

2.4.1.6 Mental health or substance use disorder treatment providers, including county behavioral health agencies

2.4.1.7 Supportive housing providers

2.4.1.8 Federally qualified health centers and rural health clinics

2.4.2 Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

2.4.3 If the CalOptima case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with Members experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations. CalOptima shall coordinate with county homelessness entities to provide these services.

2.4.4 Members who meet the eligibility requirements for Housing and Tenancy Support Services shall also be assessed for ECM and may have received Housing Transition/Navigation services. When enrolled in ECM, Community Supports shall be managed in coordination with ECM providers. When Members receive more than one of these services, CalOptima shall ensure it is coordinated by an ECM provider whenever possible to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management.

ATTACHMENT B

PROCEDURES FOR REQUESTING INTERPRETATION SERVICES

ARTICLE 1
CALOPTIMA DIRECT MEMBERS

1.1 CalOptima Responsibilities. CalOptima shall provide Members enrolled in CalOptima Direct (COD) with face-to-face language and sign language interpretation services to ensure effective communication with Providers. Upon notification from Provider pursuant to the provisions of this Contract that interpreter services are required, CalOptima shall arrange for and make payment for interpreter services for COD Members in accordance with the procedures set forth herein.

1.2 Request for Interpretation Services. To request these interpretation services Provider shall, at least one week before the scheduled appointment with the Member, contact CalOptima Customer Service Department at (714) 246-8500 to be connected with the Cultural and Linguistic (C&L) Coordinator. The following information will be needed at the time of the request:

a. Member name and ID, date of birth and telephone number;

b. Name and phone number of the care taker, if applicable;

c. Language or sign language needed;

d. Date and time of the appointment;

e. Address and telephone number of the facility where the appointment is to take place;

f. Estimated amount of time the interpretation service will be needed; and

g. Type of appointment: assessment, fitting/delivery or other.

1.3 Provider's Responsibilities.

1.3.1 C&L Coordinator. Provider shall make the request at least one week before the scheduled appointment. Provider shall communicate with the CalOptima C&L Coordinator. CalOptima C&L Coordinator will make the best effort to secure an interpreter within 72 hours of a request, and will confirm to the Provider and Member of the result of this effort.

1.3.2 Appointment Changes. If there is any change with the appointment, Provider shall contact CalOptima C&L Coordinator, at least 72 hours before the scheduled appointment.

1.3.3 Provider Obligation For Cost. If Provider fails to communicate with CalOptima C&L Coordinator in a timely manner (less than 72 hours before the appointment), Provider will have to incur the cost of an urgent interpretation service request.

ARTICLE 2
HEALTH NETWORK MEMBERS

Health Network Contact. Provider shall contact Member's Health Network customer service department to request the needed interpretation services and shall follow the Health Network policy and procedures for those services.

ATTACHMENT C

COMPENSATION

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the following amounts:

I. Medi-Cal Program Reimbursement
For Medi-Cal Members, CalOptima shall reimburse for Covered Services as follows:

Recuperative Care (Medical Respite)

Rate	$
Unit of Service	Per Diem
HCPCS Billing Code	T2033 (Modifier U6 for both)

Housing Deposits

Service Rate	Up to a Maximum of $
Unit of Service	The amount of the Housing Deposit advanced, up to the Maximum allowed
HCPCS Billing Code	H0044 (U2 Modifier)

Housing Transition Navigation Service Rate

Bundled Payments (per Enrollee per Month (PEPM))	$
Unit of Service	PEPM
HCPCS Billing Code	H0043, H2016 (Modifier U6 for both)

Housing Tenancy and Sustaining Service Rate

Bundled Payments (per Enrollee per Month (PEPM))	$
Unit of Service	PEPM
HCPCS Billing Code	T2040, T2041 (Modifier U6 for both)

ATTACHMENT D

DISCLOSURE FORM

_____
Name of Provider

The undersigned hereby certifies that the following information regarding

_____ (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

_____

_____

Co-Owner(s):

_____

_____

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

_____

_____

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

_____

_____

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

_____

_____

Dated: _____ Signature: _____

Name: _____
(Please type or print)

Title: _____
(Please type or print)

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ADDENDUM 1
MEDI-CAL PROGRAM

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medi-Cal Program (COD and Health Network Members): These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Records Retention. Provider shall maintain and retain all records of all items and services provided Members for a term of at least ten (10) years from the final date of the contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Provider's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

   Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Provider shall, upon request, transfer copies of such records to CalOptima's possession.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

2. Access to Books and Records. Provider agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the DHCS Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima, the Government Agencies, CalOptima's Regulators, DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, (b) at all reasonable times at Provider's place of business or at such other mutually agreeable location in California, and (c) in a form maintained in accordance with the general standards applicable to such book or record keeping for a term of at least ten (10) years from the final date of the Contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later, in which the records or data were created or applied, and for which the financial record was completed, and including, if applicable, all Medi-Cal 35 file paid claims data and encounter data for a period of at least ten (10) years from the date of expiration or termination. Provider shall provide access to all security areas and shall provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to

suspend or terminate the Provider from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract for provision of services to CalOptima Medi-Cal Members due to fraud.

Provider shall cooperate in the audit process by signing any consent forms or documents required by but not limited to: DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima to release any records or documentation Provider may possess in order to verify Provider's records.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

3. Form of Records. Provider's and its Subcontractors' books and records shall be maintained in accordance with the general standards applicable to such book or record-keeping.

4. Third Party Tort Liability/Estate Recovery. Provider shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, or casualty liability insurance awards and uninsured motorist coverage. Provider shall identify and notify CalOptima, within five (5) calendar days of discovery, which shall in turn notify DHCS, of any action by the CalOptima Member involving the Tort Workers' Compensation liability of a third party or estate recovery that could result in recovery by the CalOptima Member of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code.

5. Records Related to Recovery for Litigation.

   5.1 Upon request by CalOptima, Provider shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Provider's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Provider or its Subcontractors related to this Contract or Subcontracts entered into under this Contract. Provider further agrees to timely gather, preserve, and provide to DHCS any records in Provider's or its subcontractor's possession, in accordance with the DHCS Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

   5.2 In addition to the payments provided for elsewhere in this Contract, CalOptima agrees to pay Provider for complying with Paragraph 5.1, above, as follows:

5.2.1 CalOptima shall reimburse Provider amounts paid by Provider to third parties for services necessary to comply with Paragraph 5.1. Any third party assisting Provider with compliance with Paragraph 5.1 shall comply with all applicable confidentiality requirements. Amounts paid by Provider to any third party for assisting Provider in complying with Paragraph 5.1, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by CalOptima.

5.2.2 If Provider uses existing personnel and resources to comply with Paragraph 5.1, CalOptima shall reimburse Provider as specified below. Provider shall maintain and provide to CalOptima time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by CalOptima.

5.2.2.1 Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to Paragraph 5.1.

5.2.2.2 Costs for copies of all documentation submitted to CalOptima pursuant to Paragraph 5.1, subject to a maximum reimbursement of ten (10) cents per copied page.

5.2.2.3 Provider shall submit to CalOptima all information needed by CalOptima to determine reimbursement to Provider under this provision, including, but not limited to, copies of invoices from third parties and payroll records.

6. Medical Records. All medical records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1936a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Provider shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Participating Provider or Subcontractor site.

7. Downstream Contracts. In the event that Provider is allowed to subcontract for services under this Contract, and does so subcontract, then Provider shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

8. Medi-Cal Policies. Covered Services provided under this Contract shall comply with all applicable Medi-Cal Managed Care Division (MMCD) Policy Letters.

9. Medi-Cal Credentialing. If Provider is of a provider type that is not able to enroll in Medi-Cal through the DHCS, Provider shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations, for its Providers.

10. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's proposal to reduce or change the hours, days, or location at which the services are

available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

11. Confidentiality of Medi-Cal Members. Provider and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Provider, its employees, or agents as a result of services performed under this Contract, except for statistical information not identifying any such person. Provider and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Provider's obligations under this Contract. Provider and its employees, or agents shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Provider from unauthorized disclosure. Provider may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Provider is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider or its Subcontractors, Provider:

11.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

11.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

11.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

11.4 will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Provider by CalOptima for this purpose.

12. Debarment Certification. By signing this Contract, the Provider agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

12.1 By signing this Contract, the Provider certifies to the best of its knowledge and belief, that it

and its principals:

12.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

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

12.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Subprovision 12.1.2 herein; and

12.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

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

12.1.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

12.2 If the Provider is unable to certify to any of the statements in this certification, the Provider shall submit an explanation to CalOptima.

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

12.4 If the Provider knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

13. DHCS Directions. If required by DHCS, Provider and its Subcontractors shall cease specified activities for CalOptima Members, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

14. Lobbying Restrictions and Disclosure Certification.

14.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

14.2 Certification and Disclosure Requirements

14.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1 to this Addendum 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 14.3 of this provision.

14.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment 2 to this Addendum 1, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 14.3 of this provision if paid for with appropriated funds.

14.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 14.2.2 herein. An event that materially affects the accuracy of the information reported includes:

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

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

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

14.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 14.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

14.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 14.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

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

continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

15. Additional Subcontracting Requirements.

15.1 Provider shall ensure that all Subcontracts are in writing and require that the Provider and its Subcontractors:

15.1.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima, DHCS, CalOptima's Regulators, and/or DOJ, or their designees.

15.1.2 Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the DHCS Contract period or from the date of completion of any audit, whichever is later.

15.2 Provider shall require all Subcontracts that relate to the provision of Medi-Cal Covered Services to Members pursuant to the Contract include the following:

15.2.1 Services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

15.2.2 Subcontract or its amendments are subject to DHCS approval as provided in the DHCS Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract.

15.2.3 An agreement that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 21 of this Addendum 1.

15.2.4 An agreement to submit provider data, encounter data, and reports related to the Subcontract in accordance with Sections 2.23 of the Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Section 5 of this Addendum 1.

15.2.5 An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for purpose of an audit, inspection, evaluation, examination, or copying, in accordance with Section 6.1 of the Contract and Sections 2 and 16 of this Addendum 1.

15.2.6 An agreement to maintain and make available to DHCS, CalOptima, and/or Provider, upon request, all sub-subcontracts related to the Subcontract, and to ensure all sub-contractors are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 15.1 of this Addendum 1.

15.2.7 An agreement to comply with CalOptima's Compliance Program (including, without limitations, CalOptima Policies), all applicable requirements or the DHCS Medi-Cal Managed Care Program, and all monitoring provisions and requests set forth in Section 16 of this Addendum 1.

15.2.8 An agreement to assist Provider and/or CalOptima in the transfer of care of a Member in the event of termination of the DHCS Contract or the Contract for any reason, in accordance with Section 19 of this Addendum 1, and in the event of termination of the Subcontract for any reason.

15.2.9 An agreement to hold harmless the State, Members, and CalOptima in the event the Provider cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.7 of the Contract.

15.2.10 An agreement to notify DHCS in the manner provided in Section 7.9 of the Contract in the event the Subcontract is amended or terminated.

15.2.11 An agreement to the provision of interpreter services to Members at all provider sites as set forth in Section 2.17 of the Contract, to comply with the language assistance standards developed pursuant to Health and Safety Code section 1367.04, and to the requirements for cultural and linguistic sensitivity as set forth in Section 2.16 or the Contract.

15.2.12 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 8.1 of the Contract.

15.2.13 An agreement to participate and cooperate in quality improvement system as set forth in Section 2.12 of the Contract, and to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies in instances where DHCS, CalOptima and/or Provider determines that the Subcontractor has not performed satisfactorily.

15.2.14 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Section 25 of this Addendum 1 and Section 6.5.3 of the Contract.

15.2.15 An agreement by the Provider to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 7.5. of the Contract.

15.2.16 An agreement for the establishment and maintenance of and access to medical and administrative records as set forth in Sections 6.2 and 6.3 of the Contract and Sections 1, 3 and 6 of this Addendum 1.

15.2.17 An agreement that Subcontractors shall notify Provider of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

15.2.18 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 6.5.3 or the Contract, which shall be signed and filed with DHCS prior to the Subcontractor being allowed access to computer files or any other data or files, including identification of Members.

16. State's Right to Monitor. Provider shall comply with all monitoring provisions of this Contract and the DHCS Contract between CalOptima and DHCS, and any monitoring requests by CalOptima and DHCS. Without limiting the foregoing, CalOptima and authorized State and Federal agencies will have the right to monitor, inspect or otherwise evaluate all aspects of the Provider's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring, inspection or evaluation activities will include, but are not limited to, inspection and auditing of Provider, Subcontractor, and provider facilities, management systems and procedures, and books and records as the Director of DHCS deems appropriate, at anytime, pursuant to 42 CFR Section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Provider. The monitoring activities will be either announced or announced. Staff designated by authorized State agencies will have access to all security areas and the Provider will provide, and will require any and all of its subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Provider and/or the subcontractor(s).

17. Provider shall comply with language assistance standards developed pursuant to Health & Safety Code Section 1367.04.

18. Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Provider 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.

19. Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's DHCS Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor DHCS Contractor, the Provider shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

20. This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract between CalOptima and DHCS.

21. Provider agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider or Subcontractor (whether in a single transaction or

in a series of transactions); (ii) the change or more than twenty-five percent (25%) of the directors of trustees of Provider of Subcontractor; (iii) the merger, reorganization, or consolidation of Provider or Subcontractor, with another entity with respect to which Provider or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Provider or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Provider or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

22. Provider further agrees to timely gather, preserve, and provide to DHCS any records in the Provider's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation Provision".

23. Provider agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason.

24. Notwithstanding anything in this Contract to the contrary, Provider shall be entitled to the protections of the Health Care Providers' Bill of Rights, California Health and Safety Code section 1375.7, in the administration of this Contract relative to the Medi-Cal program.

25. If and to the extent that the Provider is responsible for the coordination of care for Members, CalOptima shall share with Provider, in accordance with the appropriate Declaration of Confidentiality signed by Provider and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and Provider shall receive the utilization data provided by CalOptima and use it as the Provider is able for the purpose of Members care coordination.

Addendum 1--Attachment 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.
This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

Addendum 1--Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract / grant / cooperative agreement / loan / loan guarantee / loan insurance	2. Status of Federal Action: bid/offer/application / initial award / post-award	3. Report Type: initial filing / material change. For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime / Subawardee Tier , if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	13. Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorizing a Contract with GA Food Services LLC for the Diabetes Mellitus Pilot Program's Fresh Produce Delivery Services

Contacts

Emily Fonda, Chief Medical Officer, (714) 246-8887
Marie Jeannis, Executive Director, Quality & Population Health Management, (714) 246-8591

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into a two-year agreement with GA Food Services (GA Foods), to support the Diabetes Mellitus Pilot Program's delivery of fresh produce effective November 13, 2021, through November 12, 2023, along with one (1) one-year extension option, exercisable at CalOptima's sole discretion.

Background

According to the American Diabetes Association, individuals with diabetes and food insecurity have a higher risk of developing complications. To reduce this risk, individuals need to learn about this complex disease and incorporate a variety of self-management behaviors into their daily lives. To better assist CalOptima members with diabetes and facilitate primary care provider (PCP) care, staff proposed to implement a multidisciplinary approach to support CCN Medi-Cal members with intermediate to poorly controlled diabetes. On August 3, 2021, staff received Board of Directors' approval to proceed with program implementation. The approval includes the services of a CalOptima pharmacist and a registered dietitian, along with PCP engagements. It also includes staff's proposal to help lower members' HbA1c levels by providing access to fresh produce for a healthy diet, subject to Department of Health Care Services' (DHCS) approval. Per DHCS' direction, upon receiving Board of Directors' approval on this recommended action, staff will submit a vendor contract and Business Associate Agreement to the state to obtain their final approval.

Nutrition and attention to food insecurity are important parts of a healthy lifestyle when managing diabetes. Following a healthy meal plan can help members keep their blood sugar in their target range. Qualified members with intermediate to poorly controlled diabetes will receive fresh produce delivered to their homes twice per month following engagement in the program.

Discussion

Staff seeks to improve member access to healthy ingredients by delivering a box of fresh produce every two weeks. The Fresh Produce Delivery Program workgroup released the Request for Proposal in July 2021 and received three proposals. The workgroup evaluated each proposal in the following five categories:

1. Technical and overall capabilities to effectively complete requirements
2. Qualifications and related experience
3. Proposal organization and completeness of response
4. Pricing

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5. Financial responsibility

One vendor progressed to the final evaluation stage, having met CalOptima's core requirements. Based on the workgroup's weighted scores and team discussion, staff recommends a contract with GA Foods. The proposal scores are listed below:

Vendor	Weighted Score
GA Foods	4.3
NationBenefits	3.61
Foodsmart	1.84

GA Foods has been a nationally recognized and trusted provider of nutrition services since 1973, meeting the unique needs of health plans, such as Medicaid, Medicare Advantage, Long-Term Services and Supports, Program of All-Inclusive Care for the Elderly and Multipurpose Senior Services Program. GA Foods designs, produces and distributes their products, which include prepared meals, shelf-stable meals and produce/grocery boxes. These products serve the post-discharge, chronic condition management and supplemental benefits segments of the managed care market.

To fulfil CalOptima's fresh produce requests, GA Foods will use its Vernon, California-based delivery fleet to personally deliver produce boxes to CalOptima members residing in Orange County through the Support Delivered @ Home (SD@H) delivery model (refer to Attachment 2). Staff believes that GA Foods is well qualified and has the necessary infrastructure across Orange County to deliver fresh produce to support CalOptima's diabetes management program with a multidisciplinary approach.

Staff anticipates expenditures of approximately $5.0 million to deliver boxes of fresh produce to members with poorly controlled diabetes during the two-year pilot period. Staff will return to the Board with further recommendations based on the results of the pilot.

Fiscal Impact
The Diabetes Mellitus Pilot Program was approved by the Board on August 5, 2021, and funds were authorized from existing reserves to support the Fresh Produce Delivery Program. The total estimated annual cost for implementing the fresh produce delivery program is approximately $2.5 million or approximately $5.0 million for the two-year period.

Rationale for Recommendations
The recommended actions will support CalOptima's innovative efforts to assist members with poorly controlled diabetes achieve healthier lifestyles and avoid complications.

Concurrence
Gary Crockett, Chief Counsel

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Attachments

1. Entities Covered by this Recommended Action
2. Previous Board Action August 5, 2021 "Consider Authorizing a Diabetes Mellitus (DM) Pilot Program to Improve Health Care Quality for Medi-Cal Members with Poorly Controlled Diabetes"
3. GA Foods_Support Delivered @ Home
4. GA Foods Contract (Template)

/s/ Richard Sanchez — *10/28/2021*
Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
GA Food Services	12200 32nd Ct N	St. Petersburg	FL	33716

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 5, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Authorizing a Diabetes Mellitus (DM) Pilot Program to Improve Health Care Quality for Medi-Cal Members with Poorly Controlled Diabetes

Contacts

Emily Fonda, Chief Medical Officer (714) 246-8887
Marie Jeannis, Executive Director, Quality & Population Health Management (714) 246-8591

Recommended Actions

1. Authorize implementation of a two-year pilot Multidisciplinary Approach to Improving Care for CalOptima Community Network (CCN) Medi-Cal members with Poorly Controlled Diabetes ;
2. Authorize up to $8.2 million in unbudgeted expenditures from reserves for the DM program; and
3. Subject to Department of Health Care Services (DHCS) approval, authorize the CEO, with the assistance of Legal Counsel, to contract with a vendor selected through the Request for Proposal (RFP) process to provide fresh produce delivery services as part of the DM program.

Background

Diabetes is a disease caused by too much sugar in the blood that requires a primary care provider's (PCP's) comprehensive care. When diabetes is not managed, it can damage vital organs and lead to various complications. Based on the Centers for Disease Control and Prevention's 2017 data[1], diabetes is the most expensive chronic condition in the United States, and the total annual cost spent on diabetes was $327 billion.

The high cost of diabetes is not just our nation's story; CalOptima is also seeing the high cost of diabetes for our CCN Medi-Cal members. Based on claims data from July 2019 through June 2020, CalOptima observed that approximately $247 million was spent on diabetic care (refer to Attachment 1). In addition to the enormous total cost, the average annual cost per diabetic member was $20,334, which is approximately four times higher than non-diabetic members' average annual cost.

Food insecurity is "a lack of consistent access to enough food for an active, healthy life and it's an issue that touches people of all ages with all types of diabetes[2]." According to the American Diabetes Association, diabetics with food insecurity have a higher risk of developing complications. Diabetes is a complex and challenging disease for members, as well as for their families and society at large. To reduce the risk of complications of diabetes, members need to learn about this complex disease and incorporate a variety of self-management behaviors into their daily lives. In order to better assist this population and facilitate PCP care, CalOptima staff proposes to offer a multidisciplinary approach to assist managing CCN Medi-Cal members with poorly controlled diabetes and their complex treatment regimens. The anticipated start date for the DM program is by the fourth quarter of 2021. The goals of this new DM program are: 1) lower HbA1c level to avoid complications; 2) reduce emergency department (ED) visits; 3) reduce hospitalization rates; 4) reduce costs for diabetic medications; 5) improve member and provider satisfaction; and 6) optimize diabetes medication management during the transition to Medi-Cal Rx. This new DM program is proposed in CalOptima's 2021 Quality Improvement (QI) Program. Through the QI

[1] https://www.cdc.gov/chronicdisease/programs-impact/pop/diabetes.htm
[2] https://www.diabetes.org/healthy-living/recipes-nutrition/food-insecurity-diabetes

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Program, CalOptima aims to continuously improve the structure, processes, and outcomes of its health care delivery system to serve our members.

Discussion

Pharmacist Involvement and Intervention

Literature shows that pharmacists involved in diabetes care and management play a pivotal role in helping members achieve healthier lifestyle goals. This active participation in diabetes care and management requires that the CalOptima pharmacist's role extends to include individual member outreach and provider consultations. CalOptima staff believes that our internal pharmacists can promote and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with PCPs and health coaches/registered dieticians/case managers. With this new DM program, CalOptima proposes to hire two Clinical Pharmacists to provide various interventions to optimize medical management. The estimated salary and benefit expenses for the two-year pilot period is $854,968.

Health Coach/Registered Dietician Intervention

CalOptima's Population Health Management department's Health Coaches have been providing chronic condition management and coaching for members. With the new multidisciplinary approach, CalOptima proposes to hire two Health Coaches to provide CCN-focused interventions such as assessment/care planning, motivational interviewing, member education materials, referral to other community resources based on needs. Health Coaches/Registered Dieticians would also participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention. The estimated salary and benefit expenses for the two-year pilot period is $509,342.

Member Health Rewards Program

Subject to DHCS approval, staff proposes supporting member engagement and compliance by providing members with member health rewards (non- monetary incentives). The non-monetary incentives will be provided as gift cards subjected to DHCS approval.

Based on claims data, staff identified poorly controlled diabetic CCN Medi-Cal members as follows:

- Total diabetic members: 12,200
    - Known poorly controlled (HbA1c > 9%): 985 (almost 9% of total diabetics)
    - Intermediate control (HbA1c >= 8-9%): 714 (almost 6% of total diabetics)
    - Adequate control (HbA1c < 8%): 4,231
    - No HbA1c test (in past 12 months): 6,270
        - Potentially poorly controlled: 564 (9% of untested)
        - Potentially intermediate control: 367 (6% untested)

To encourage all CCN Medi-Cal members with diabetes to regularly monitor their blood sugar levels, staff recommends providing $25 non-monetary health rewards (e.g., gift cards) for those who complete their HbA1c test on an annual basis (eligible once a calendar year).

For those members with poorly controlled HbA1c levels, staff recommends providing $50 health rewards for reducing HbA1c levels by full 1 percentage point, for example, from HbA1c 10 to 9.

(eligible twice a year, totaling up to $100). For the 6,270 members who have not had HbA1c test, there is a possibility that 9% (564) of this population may be identified as poorly controlled based on the trends. There is also a possibility that 6% (367) of this population may be identified as intermediate control based on the trends.

Lastly, staff proposes offering $25 health rewards for those members with adequately maintained HbA1c levels for one year (HbA1c less than 8%).

Staff assumes a predicted participation rate of 80%. The total estimated cost for implementing these Health Rewards Programs for a two-year period is $1,103,040.

Description	**Amount**
$25 Non-monetary health rewards for HbA1c test completion	$244,000
$50 Health reward to improve HbA1c control by 1%	$210,400
$25 Health reward to maintain adequate control	$84,620
Annual Total	$539,020
Provider/member educational expenses	$25,000
Two-year pilot total	**$1,103,040**

Provider Incentives
For providers, staff plans to promote the existing Board-approved Pay for Value (P4V) CCN Program. The program was approved by the Board of Directors on February 6, 2020 and is currently approved through calendar year 2021 and encourages CCN providers to provide timely preventive health care services, deliver excellent outcomes, and achieve and maintain high levels of member satisfaction. In addition to the P4V program, in order to have successful provider buy-ins, staff proposes providing additional incentives for a year participation in the DM program. The additional incentives would not require provider contract amendments.

Providers are eligible for incentives when they participate in the program to manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.

To be eligible for these additional rewards:

- Year 1: $150
    - PCP to schedule appointment and see member
    - Order HbA1c lab test
    - PCP to have a consultation with CalOptima pharmacist to review the medication review tool list along with pharmacy recommendations and consider making changes
        - CalOptima Pharmacy documentation of PCP participation
- Year 2: $200
    - If a PCP manages to lower an eligible member's HbA1c < 8%, the PCP would be eligible to receive an additional $200 (one time per member).

Staff assumes a predicted participation rate of 80%. The total estimated cost for implementing provider incentives for a two-year period is $736,400.

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Description	Amount
Year 1 Provider Incentives	$315,600
Year 2 Provider Incentives	$420,800
Two-year pilot total	**$736,400**

Fresh Produce Delivery Program
Along with physician activity, nutrition and attention to food insecurity are important parts of a healthy lifestyle when managing diabetes. Following a healthy meal plan can help members keep their blood sugar in their target range. Subject to DHCS approval, staff proposes including a fresh produce delivery service in this new multidisciplinary DM program to support an appropriate meal plan, based on a recommended American Diabetes Association diet, for our CCN Medi-Cal poorly controlled diabetic members.

In order to qualify for food delivery, members must meet the following requirements:

- Have an appointment with their PCP and have HbA1c lab test
- Lab results indicates that HbA1C >= 8
- Have consultation with CalOptima Pharmacist
- Have consultation with CalOptima Registered Dietician

Qualified members with intermediate to poorly controlled diabetes will receive fresh produce delivered to their homes twice per month following engagement in the program.

Staff assumes a predicted participation rate of 80%. The total estimated annual cost for implementing the fresh produce delivery program is $ $2,474,304 or $4,948,608 for the two-year period.

Staff released the RFP in early July 2021 and requested DHCS' approval. Staff will return to the Board to seek approval to contract with the recommended Fresh Produce Delivery Program vendor identified through the RFP process.

Evaluation Goals
During the two-year pilot intervention, staff proposes to review members' progress on a semiannual basis and study the following annually:

Hospitalization rates	Member satisfaction (survey)
% reduction in members with HbA1c > 9	Provider satisfaction (survey)
Rate of medication adherence	Review pharmaceutical cost savings
Participation rate	ED visits/rates

To measure member and provider satisfaction, staff proposes conducting a before-and-after survey. The estimated mailing cost for conducting a before-and-after survey is $7,500.

Fiscal Impact
The recommended action is unbudgeted. A proposed allocation of up to $8.2 million from existing reserves will fund this action.

Rationale for Recommendations
The recommended actions will support CalOptima's efforts to assist members with poorly controlled diabetes achieve healthier lifestyles and avoid complications.

Concurrence
Gary Crockett, Chief Counsel
Quality Assurance Committee

Attachments
1. Cost Comparison Diabetic vs. Non-Diabetic Members
2. PowerPoint Presentation
3. Draft Scope of Work

/s/ Richard Sanchez *07/28/2021*
Authorized Signature **Date**

Cost Comparison - Diabetic vs. Non-Diabetic Members

From: 2019-07 Through: 2020-06 For CCN - MC

	Distinct Members		Total Amount Paid		Avg Cost Per Member		% of Population Utilizing Services	
	Diabetic	**Non-Diabetic**	**Diabetic**	**Non-Diabetic**	**Diabetic**	**Non-Diabetic**	**Diabetic**	**Non-Diabetic**
Grand Total	12,200	69,426	$247,898,668	$370,585,854	$20,320	$5,338	100.0%	100.0%
LTC	340	298	$28,569,377	$25,269,785	$84,028	$84,798	2.8%	0.4%
Inpatient	2,087	6,082	$73,209,011	$97,481,773	$35,079	$16,028	17.1%	8.8%
Hospice	144	273	$1,875,977	$2,465,905	$13,028	$9,033	1.2%	0.4%
Outpatient	7,036	28,775	$41,171,497	$51,745,653	$5,852	$1,798	57.7%	41.4%
Pharmacy	11,821	55,186	$56,199,373	$88,097,684	$4,754	$1,596	96.9%	79.5%
Professional	11,609	64,740	$46,873,433	$105,525,053	$4,038	$1,630	95.2%	93.3%

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Diabetic with HbA1c > 9

*Latest from last 12 months

Total	12,200
HbA1c > 9	985
HbA1c <= 9	4,945
No HbA1c Result	6,270

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A Public Agency

CalOptima

Better. Together.

Multidisciplinary Approach to Improve Care in Poorly Controlled Diabetics

Board of Directors Meeting
August 5, 2021

Emily Fonda, MD, MMM
Chief Medical Officer

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Diabetes

- Seventh leading cause of death in California
- Total annual national cost of diabetes in 2017 was $327 billion
- Total annual cost for diabetes is more than $247 million for Medi-Cal and CalOptima Community Network (CCN)
  - Pharmacy costs more than $56 million

Sources:

- Centers for Disease Control and Prevention, National Center for Health Statistics & National Center for Chronic Disease Prevention and Health Promotion
- National Center for Biotechnology Information, U.S. National Library of Medicine

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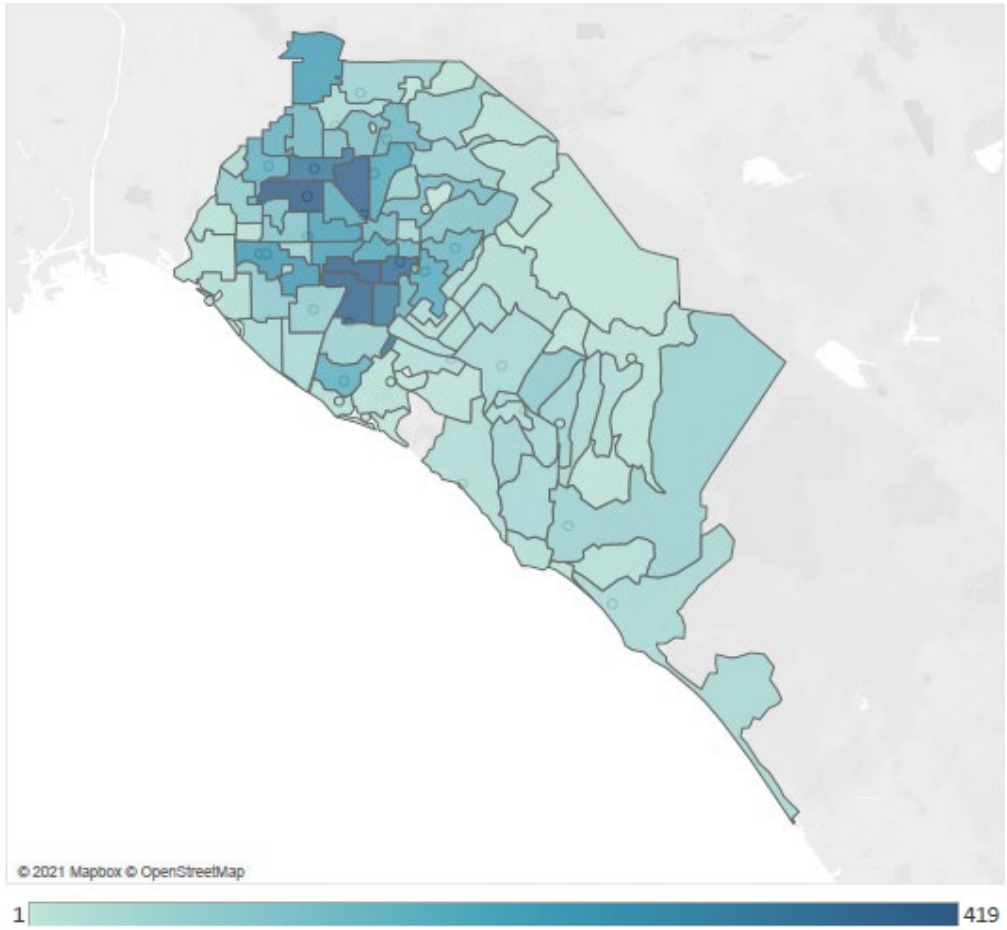
Members with Diabetes by Location

From: 2019-07 Through: 2020-06 For CCN - MC

*Includes diabetic members with poor HbA1c control, intermediate HbA1c control, and no recent HbA1c results available (approx. 8,000)



Top 10 ZIP Codes by Member Count

92804	421
92703	407
92805	406
92704	404
92701	373
92801	335
92707	326
92683	248
92840	225
92843	219

Top 10 Cities by Member Count

Santa Ana	1,854
Anaheim	1,603
Garden Grove	643
Orange	533
Fullerton	444
Buena Park	358
Costa Mesa	256
Westminster	253
Irvine	235
Huntingtn Bch	162

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Two-Year Pilot Proposal

- Multidisciplinary approach to care for CCN members with poorly controlled diabetes
- Goal: lower HbA1c to < 8% to reduce complications
- Key Components:
  - Collaborate with CalOptima pharmacists, health coaches and registered dietitians
  - Provider incentives
  - Member health rewards and fresh produce delivery
- Estimated cost: $8.2 million

Source: American Diabetes Association, Diabetes Care

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Pharmacist, Health Coach and Registered Dietician

- Extend CalOptima pharmacist's role to include individual member outreach with consultation
- Consult with Primary Care Physician (PCP)
- Develop specific assessments to support the program and care planning
- Provide targeted education materials
- Conduct motivational interviewing
- Collaborate with the multidisciplinary team
- Refer members to other community resources

Provider Incentives

- Motivate providers to deliver improved outcomes
  - Separate from Pay for Value Program (P4V)
    - P4V includes comprehensive diabetes care
- PCP incentive eligibility criteria
  - Schedule appointment to see member with poorly controlled diabetes
  - Order HbA1c lab test
  - Consult with CalOptima pharmacist
- Recommended incentives
  - Year 1: $150 per member in the program and completing eligibility criteria
  - Year 2: $200 per member if a PCP manages to lower the member's HbA1c level < 8%

Member Health Rewards*

- Recommend health rewards for all members with diabetes
  - 12,200 members identified with diabetes
    - $25 reward for completing their annual HbA1c test
  - 2,630 members with intermediate to poorly controlled HbA1c level >= 8%
    - $50 reward for reducing HbA1c level by 1%
    - Eligible twice a year for up to $100 for reducing by 2%
  - 4,231 members with HbA1c level < 8% maintained for one year (intermediate to adequate control)
    - $25 reward for maintaining their HbA1c level <8% for one year

*Subject to DHCS approval

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Fresh Produce Delivery Program*

- Support access to nutritious food to improve outcomes
- Eligibility criteria
  - Complete appointment with PCP and have HbA1c lab test
  - Receive lab results indicating HbA1c level >= 8%
  - Consult with CalOptima pharmacist
  - Consult with CalOptima registered dietitian
- Eligible members will receive a fresh produce box delivered to their homes twice per month
- RFP issued on 7/1 and DHCS approval requested

*Subject to DHCS approval

Source: American Diabetes Association

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Next Steps

- Return to the Board in November to secure approval of Food Delivery Vendor
- Implement program by the fourth quarter of 2021
- Track outcome measures

• Member Satisfaction (Before/After Survey)	• Provider Satisfaction (Before/After Survey)
• ED visits/rates	• Hospitalization rates
• Rate of medication adherence	• Prescription cost savings
• Percent reduction in members with HbA1c level >=8%	• Program participation rate

- Return to the Board with an annual update

Our Mission

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

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Scope of Work

A. OBJECTIVE

CalOptima is seeking to partner with a contractor who can offer a fresh produce delivery program so CalOptima Community Network (CCN) Medi-Cal members can cook healthy and nutritious meals to manage their diabetic conditions.

Along with physician activity, nutrition and attention to food insecurity are important parts of a healthy lifestyle when managing diabetes. Following a healthy meal plan can help members keep their blood sugar in their target range. Therefore, CalOptima is planning to include a fresh produce delivery into our new multidisciplinary diabetes mellitus (DM) program to support an appropriate meal plan, based on a recommended American Diabetes Association diet, for our intermediate to poorly controlled diabetic members.

Fresh produce means fruits and vegetables that have not been processed in any manner.

Estimated eligible members: 3,000 diabetics

Eligible members will receive fresh produce delivered to their homes (in Orange County, California) twice per month following engagement in the program.

The successful Offeror must offer a variety of fresh produce options so members can select or customize fruits/vegetables based on their preference.

This is a two-year pilot program, and the tentative anticipated go live date is by quarter four of 2021.

B. CONTRACTOR'S RESPONSIBILITIES

The successful Offeror shall:

1. Prepare and deliver fresh produce boxes in sufficient quantity and quality within the time frame agreed to with CalOptima and/or members.

2. Maintain appropriate and current state and/or local certification demonstrating adequate fresh produce preparation facilities and transportation resources.

3. Cooperate in any member satisfaction survey which CalOptima's DM program may choose to undertake.

4. As part of their proposal, the Offeror shall submit the following:

    a. Certificate of Insurance as cited in the Sample Contract.
    b. Comprehensive general liability
    c. Automobile liability insurance
    d. Workers' compensation certificate

e. Copy of Health Inspection Report and Copy of Seal provided by Orange County Health Department
f. Emergency preparedness plan

Delivery/Hours of Operation

- The successful Offeror must be able to deliver a fresh produce box to eligible members twice per month.
- The successful Offeror must be able to allow members to choose their delivery days.
- The successful Offeror must demonstrate proof of fresh produce delivery and provide data to CalOptima that includes a member's (or household member's) signature.
- The successful Offeror must provide a customer service line dedicated to our members.
- The successful Offeror must provide a point of contact for CalOptima who shall be available during CalOptima's normal business hours, excluding federal and state designated holidays, to receive inquiries by telephone or email.

Sanitation/Safety

- The successful Offeror will warrant that all food shall be fresh, clean, wholesome upon delivery, and prepared in properly equipped facilities under modern sanitary conditions in accordance with the best industry practice.
- All items shall be free from decay, discoloration, foreign matter, and shall pass through metal detection before packaging. Boxes shall be clean, sound, compact, sturdy, and sealed.
- The successful Offeror must have a process to address member satisfaction issues related to food delivery delays, decay or quality of produce.
- All products shall bear visible freshness code dates and shall meet industry standards for remaining shelf-life upon delivery to the members.

Nutrition Information

- The successful Offeror is required to provide complete product information sheets for all fresh produce items included in the proposal, indicating pack size, weight per unit, and nutritional analysis within 30 days of contract award.
- Product information sheets may be submitted in either hard copy or in electronic format.

CalOptima's Sign-Up Process

The successful Offeror must have the ability to ensure the safe handling of sensitive data including member's Protected Health Information (PHI). Proposals must include a description of the Offeror's ability to ensure the appropriate handling of this information, the security tools in place, and security policies and procedures.

The successful Offeror shall understand CalOptima's tentative member sign-up process and support CalOptima meeting this process goal.

After having consultations with a Primary Care Provider (PCP), CalOptima Pharmacist and CalOptima Registered Dietician (RD), CalOptima will identify and inform an eligible member that they can participate in a fresh produce delivery program. After receiving a list of eligible members, the successful Offeror shall work with CalOptima to determine specific delivery/member engagement turnaround times.

Payments (Monthly Invoices)

The successful Offeror shall provide a monthly detailed invoice for fresh produce delivered to member's home. Invoice to include the following information (examples):

- Member name (may also include member Client Identification Number [CIN])
- Date of delivery
- Time of delivery
- Replacement of items (if any)
- Contract/Purchase Order Number

Performance Measures:

Performance and progress monitoring will be performed quarterly and conducted by the CalOptima DM Program leadership. Performance measures or outcome measures shall be met for the successful Offeror to be considered in compliance.

The successful Offeror shall:

- Maintain environmental health inspections in good standing.
- Changes in fresh produce (if any) submitted no less than one week prior to next delivery.
- Ensure monthly approval of fresh produce by the successful Offeror's dietitian or nutritionist and CalOptima RD prior to finalizing fresh produce options.
- Deliver fresh produce at the scheduled time (+/- 60 minutes of the stated time.)

C. CALOPTIMA RESPONSIBILITIES

- CalOptima will submit required member information to the successful Offeror to process fresh produce deliveries to eligible members.
- CalOptima shall maintain and provide a current point of contact for any inquiries by the successful Offeror.
- Some members may use CalOptima's Interpreter Services when interacting with the successful Offeror. CalOptima provides Interpreter Services as needed to accommodate members' requests. CalOptima's Interpreter Services are available for members at no cost. For calls other than English and cannot be answered by a bilingual staff, a Successful Offeror must support and work with CalOptima's Interpreter Services for various languages and dialects.
- CalOptima shall provide monitoring and oversight of the successful Offeror services.
- CalOptima will make payment to the successful Offeror within thirty (30) business days from receipt of an invoice of services provided by the successful Offeror under this contract.

Support Delivered @ Home

Addressing Member Social Determinants of Health

- Coordinated approach addresses key **Social Determinants of Health**
- Program is built around our nearly 50-year history of providing in-home services for older adults and those needing additional support to remain independent.
- Program design aimed at **CAHPS, HEDIS, and Star measures**
- Our program serves as an **early point of intervention** for the many non-medical issues that can:
  - Impact your members' overall health
  - Improve engagement
  - Increase satisfaction

GA foods

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CONTRACT NO. 22-10268
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA
And
G.A. FOOD SERVICES OF PINELLAS COUNTY, LLC, dba GA FOODS
(CONTRACTOR)

THIS CONTRACT ("Contract") is made and entered into as of the date last signed below, by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima" and G.A. Food Services of Pinellas County, LLC, dba GA Foods, a Limited Liability Company, hereinafter referred to as "CONTRACTOR." CalOptima and CONTRACTOR shall be referred to herein collectively as the "Parties" or individually as a "Party."

RECITALS

A. CalOptima desires to retain a CONTRACTOR to provide Fresh Produce Delivery Program Services, as described in the Scope of Work; and

B. CONTRACTOR provides such services; and

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

D. CONTRACTOR desires to perform these services for CalOptima; and

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

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. This Contract shall include the following documents ("Contract Documents"), in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and attachments, and any amendments thereto; (ii) CalOptima's Request for Proposal ("RFP") 22-001, inclusive of any revisions, amendments and addenda thereto; (iii) CONTRACTOR's proposal dated 08/10/2021. Any new terms and conditions attached to CONTRACTOR's best and final offer, proposal, invoices, or request for payment, shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All documents attached to this Contract and/or referenced herein as a "Contract Document" are incorporated into this Contract by this reference, with the same force and effect as if set forth herein in their entirety. Changes hereto shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima and issued in accordance with Section 17, Modifications, herein. In the event of any conflict of provisions among the documents constituting the Contract, the provisions shall prevail in the above-referenced descending order of precedence.

2. Statement of Work.

2.1 CONTRACTOR shall perform the work necessary to complete, in a manner satisfactory to CalOptima, and if applicable, to the Centers for Medicare and Medicaid Services ("CMS"), the California Department of Health Care Services ("DHCS"), and/or the California Department of Managed Health Care ("DMHC"), as applicable, the services set forth in Exhibit A entitled "Scope of Work," which is attached hereto and incorporated herein by this reference. CONTRACTOR shall also perform in accordance with its Proposal dated 08/10/2021.

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3. Insurance.

3.1 Prior to undertaking performance of services under this Contract and at all times during performance hereunder, and entirely at CONTRACTOR's sole expense, CONTRACTOR shall maintain the following insurance, which shall be full-coverage insurance not subject to self-insurance provisions, and CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the term of this Contract:

3.1.1 Required Insurance:

3.1.1.1 Commercial General Liability, including Contractual liability and coverage for Independent Contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

3.1.1.2 Per Occurrence: $1,000,000

3.1.1.3 Personal Advertising Injury: $1,000,000

3.1.1.4 Products Completed Operations: $2,000,000

3.1.1.5 General Aggregate: $2,000,000

3.1.2 Commercial Automobile Liability covering any auto, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

3.1.3 Workers' Compensation and Employers' Liability Policy written in accordance with the laws of the State of California and providing coverage for all of CONTRACTOR's employees:

3.1.3.1 This policy must provide statutory coverage for Workers' Compensation.

3.1.3.2 This policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

3.1.4 Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and theft of client property, with the following minimum limits of $1,000,000 per occurrence:

3.1.4.1 Cyber and Privacy Liability insurance with the following minimum limits of insurance covering claims involving privacy violations, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security. Such coverage is required only if any products and/or services related to information technology (including hardware and/or software) are provided to Insured and for claims involving any professional services for which CONTRACTOR is engaged with Insured for such length of time as necessary to cover any and all claims.

a) Privacy and Network Liability: $1,000,000

b) Internet Media Liability: $1,000,000

c) Business Interruption & Expense: $1,000,000

d) Data Extortion: $1,000,000

e) Regulatory Proceeding: $1,000,000

f) Data Breach Notification & Credit Monitoring: $1,000,000

3.2 Prior to commencement of any work hereunder, CONTRACTOR shall furnish to CalOptima's Purchasing Department additional insured endorsements and also broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR, and further providing that:

Certificate Requirements:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this contract, the CONTRACTOR's insurance coverage shall be primary insurance as respects to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies.

3.2.3 The Insurance Company agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the CONTRACTOR for CalOptima. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this clause. All certificates and endorsements are to be received and approved by CalOptima before work commences. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If CONTRACTOR maintains higher limits than the minimums required above, CalOptima requires and shall be entitled to coverage for the higher limits maintained by

CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

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

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

3.4 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

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

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR agrees to and shall save, defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "Indemnified Parties") from and against any liability whatsoever, based or asserted upon any services of the CONTRACTOR, its officers, employees, subcontractors, agents, or representatives (individually and collectively referred to as "Indemnitors") arising out of or in any way relating to this Contract, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever arising from the performance of Indemnitors under this Contract. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions, at its sole expense, which shall include all costs and fees, including, but not limited to, attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding.

4.2 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder. The terms of this Contract are contractual and the result of negotiation between the Parties hereto. Accordingly, any rule of construction of contracts (including, without limitation, California Civil Code Section 1654) that ambiguities are to be construed against the drafting party, shall not be employed in the interpretation of this Contract.

4.3 CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except Claims arising through the sole negligence or sole willful misconduct of CalOptima.

4.4 It is expressly understood and agreed that the foregoing provisions are intended to be as broad and inclusive as permitted by the law of the State of California and that CONTRACTOR's indemnification and duty to defend obligation hereunder shall survive the expiration or earlier termination of this Contract until such time as action against the Indemnified Parties for such matter indemnified hereunder is fully and finally barred by the applicable statute of limitations,

including but not limited to those set forth under the California Government Claims Act (Cal. Gov. Code §900 et seq.).

4.5 It is not the intent of the Parties that the provisions of this Section and the Indemnification provision(s) set forth in the Business Associate Protected Health Information Disclosure Agreement executed by the Parties shall be in conflict. In the event of any conflict, the Indemnification provision(s) in the Business Associate Protected Health Information Disclosure Agreement shall be interpreted to relate only to matters within the scope of that Agreement.

4.6 The terms of this Section shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which term shall include any and all subcontractors, and any agents or employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control, and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees in connection with this Contract, and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters. At CONTRACTOR's expense as described herein, CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of CONTRACTOR's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "Employment Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

6. Assignments; Subcontracts.

6.1 Except as specifically permitted hereunder, CONTRACTOR may not assign, transfer, delegate or subcontract any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion. In the event CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, delegation, or subcontract may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, delegation, or subcontract made without CalOptima's express written consent shall be deemed void.

6.2 For purposes of this Section and this Contract, assignment is: (1) the change of more than twenty-five percent (25%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than twenty-five percent (25%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g. the Board of Directors) to a third-party management person, company, group, team or other entity.

6.3 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Non-Exclusive Relationship. It is understood by the parties that this is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that

are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services. In the event CalOptima contracts with more than one contractor to provide similar or like services, the CONTRACTOR has the right to renegotiate the rates.

8. Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima Policies relating to services under the Contract that are in effect when this Contract is signed or which may come into effect during the term of this Contract.

9. Nondiscrimination Clause Compliance.

9.1 During the performance of this Contract, CONTRACTOR and its subcontractor(s) shall not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, medical condition (including cancer), age (over 40), marital status, and the use of family and medical care leave and pregnancy disability leave. CONTRACTOR and subcontractor(s) shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. CONTRACTOR and subcontractor(s) shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq. and the applicable regulations promulgated thereunder Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in Chapter 5 of Division 4, Title 2, CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. CONTRACTOR and its subcontractor(s) shall give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. CONTRACTOR shall also fully comply with the following, to the extent applicable to the services provided by CONTRACTOR under this Contract: Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as California Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); California Civil Code Section 51 (all types of arbitrary discrimination); and all rules and regulations promulgated pursuant thereto.

9.2 CONTRACTOR shall include the nondiscrimination and compliance provisions of Section 9 in all subcontracts under this Contract.

10. Prohibited Interest.

10.1 CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict of interest laws, including but not limited to CalOptima's Conflict of Interest Code, the California Political Reform Act (Government Code Section 81000 et seq.) and Government Code Section 1090 et seq. (collectively, the "Conflict of Interest Laws").

10.2 CONTRACTOR covenants that, for the term of the Contract, no director, officer, or employee of CalOptima during his tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the term of this Contract, and consistent with the provisions of Title 22 California Code of Regulations (CCR) Section 53600(f), no state officer

or state employee shall be employed in a management or contractor position by CONTRACTOR within one year after the state office or state employee has terminated state employment.

10.3 No employee, officer or agent of CalOptima shall participate in the selection, award or administration of an agreement, or in any decision that may have foreseeable impact on CONTRACTOR if a conflict of interest, real or implied, exists. Such a conflict arises when any of the following has a financial or other interest in the firm selected for award:

10.3.1 A CalOptima employee, officer or agent;

10.3.2 Any member of the employee, officer or agent's immediate family;

10.3.3 The employee, officer or agent's domestic or business partner; and

10.3.4 An organization that employs or is about to employ any of the above.

10.4 CONTRACTOR understands that, if this Contract is made in violation of Government Code Section 1090 et seq., the entire Contract is voidable and CONTRACTOR will not be entitled to any compensation for Services performed pursuant to this Contract and CONTRACTOR will be required to reimburse CalOptima any sums paid to CONTRACTOR. CONTRACTOR further understands that, in addition to the foregoing, CONTRACTOR may be subject to criminal prosecution for a violation of Government Code Section 1090.

10.5 If CONTRACTOR hereinafter becomes aware of any facts, which might reasonably be expected to either create a conflict of interest under the Conflict of Interest laws or violate the provisions of this Section, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include, without limitation, identification of all persons, entities and businesses implicated and a complete description of all relevant circumstances.

11. Disclosure of Officers, Owners, Stockholders and Creditors. On an annual basis and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit I, attached hereto and incorporated by this reference:

11.1 All officers and owners who own greater than 5% of the CONTRACTOR; and

11.2 All stockholders owning greater than 5% of any stock issued by CONTRACTOR.

11.3 All creditors of CONTRACTOR's business if such interest is over 5%.

12. Equal Opportunity.

12.1 CONTRACTOR and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. CONTRACTOR and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. CONTRACTOR and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or Department of Health Care Services ("DHCS"), setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of

1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state CONTRACTOR and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

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

12.3 CONTRACTOR and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of CONTRACTOR and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

12.4 CONTRACTOR and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

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

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

12.7 CONTRACTOR and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,'

and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or CONTRACTOR. CONTRACTOR and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event CONTRACTOR and its Subcontractors become involved in, or are threatened with litigation by a subcontractor or CONTRACTOR as a result of such direction by DHCS, CONTRACTOR and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

13. Standard of Performance; Warranties.

13.1 CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

13.2 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work.

13.3 CONTRACTOR expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including, without limitation, CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. CONTRACTOR further warrants that all material covered by this Contract, if any, which is the product of CONTRACTOR will be new and unused unless otherwise specified, and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to CONTRACTOR, CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage to other parts of the system resulting from such defects. CalOptima shall give notice to CONTRACTOR of any observed defects. In the event that CONTRACTOR fails to make adjustments, repairs, corrections, or other work made necessary by such defects, CalOptima may do so and charge CONTRACTOR the costs incurred.

13.4 CONTRACTOR's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

13.5 CONTRACTOR's obligations under this Section are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both parties.

13.6 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair and replacement by CONTRACTOR at no cost to CalOptima.

14. Compensation.

14.1 Payment.

14.1.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full consideration for the faithful performance of this Contract, the rates, charges and other payment terms identified in Exhibit B, which is attached hereto and incorporated herein by this reference.

14.1.2 CalOptima will not reimburse CONTRACTOR any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

14.1.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance as set forth in the Contract and Exhibit A, Scope of Work that may be reasonably expected by CalOptima. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING UNDER THIS CONTRACT.**

14.1.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in the attached Exhibit B, without the express prior written authorization of CalOptima. CONTRACTOR shall at all times monitor its costs and expenditures for work performed under this Contract, and shall monitor its invoices, costs, and expenditures, to ensure it does not exceed the maximum cumulative payment obligation set forth herein. CONTRACTOR shall provide CalOptima with 60 days written notice if at any time during this Contract CONTRACTOR becomes aware that it may exceed the maximum cumulative payment obligation authorized under this Contract. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

14.1.5 The maximum cumulative payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. CONTRACTOR is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise to be paid by CalOptima to CONTRACTOR due to CONTRACTOR'S failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed and pay them to the appropriate taxing authority, and shall have no liability for or any obligation to refund any payments withheld.

14.2 Contractor Travel Policy. CONTRACTOR is not entitled to any reimbursement for travel, meals, accommodations, or other similar expenses under this Contract.

15. Term. This Contract shall commence on the date last signed below, and shall continue in full force and effect through 11/12/2023, ("Initial Term"), unless earlier terminated as provided in this Contract. At the end of the Initial Term, CalOptima may, at its option, extend this Contract for up to one (1) additional consecutive one (1) year terms ("Extended Terms"), provided that if CalOptima does not exercise its option to extend at the end of the Initial Term, or any Extended Term, the remaining option(s) shall automatically

lapse. As used in this Contract, the word "Term" shall include the Initial Term and any and all Extended Term(s), to the extent CalOptima exercises its option pursuant to this paragraph.

16. Termination.

16.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days written notice hereof. Upon termination, CalOptima may pay CONTRACTOR its allowable cost incurred for services satisfactorily performed and accepted by CalOptima as of the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

16.2 CONTRACTOR may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CalOptima ninety (90) days written notice hereof.

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

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

16.3.2 In the event of Termination for Unavailability of Funds, as provided in this Section, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items, including, without limitation, lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

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

16.4 Termination for Default. Subject to a ten (10) day cure period, CalOptima may terminate this Contract for CONTRACTOR's default, or if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR, or if CONTRACTOR makes an assignment for the benefit of creditors as defined in Section 6, or if CONTRACTOR breaches any term(s) or violates any provision(s) of this Contract and does not cure such breach or violation within ten (10) days after written notice thereof by CalOptima. In the event of Termination for Default, as provided by this Section, CONTRACTOR shall be liable for any and all reasonable costs incurred by CalOptima as a result of such default, including, but not limited to, reprocurement costs of the same or similar services defaulted by CONTRACTOR under this Contract.

16.5 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3, (Insurance), Section 10, (Prohibited Interest), or Section 24, (Confidentiality).

16.6 Effect of Termination. Upon expiration or receipt of a termination notice under this Section:

16.6.1 CONTRACTOR shall promptly discontinue all services (unless the notice directs otherwise), and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs and any other products, data and such other materials, equipment, and information, including but not limited to confidential information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure. Failure to return any information or equipment, badge or access card, is considered a material breach of this Contract and CalOptima's privacy and security rules.

16.6.2 CalOptima may take over the services, and may award another party a contract to complete the services under this Contract.

16.6.3 CalOptima may withhold from payment any sum that it determines to be owed to CalOptima by CONTRACTOR, or as necessary to protect CalOptima against loss due to outstanding liens or claims of former lien holders.

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

18. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, or the California Department of Health Care Services, or the California Department of Managed Health Care, or the Department of Justice, or the Bureau of Medical Fraud, copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement between a subcontractor and an organization related to the subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

19. Confidential Material.

19.1 During the term of this Contract, either Party may have access to confidential material or information ("Confidential Information") belonging to the other Party or the other Party's customers, vendors, or partners. "Confidential Information" shall include without limitation the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements and licensing plans or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

19.2 For the purposes of this Section 19, "Confidential Information" does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other's Confidential Information or proprietary information; (iv) is received from a third party which is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure pursuant to California Public Records Act, Government Code Section 6250 et seq., applicable provisions of California Welfare and Institutions Code or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

19.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers or agents on a "need to know" basis in connection with the services performed under this Contract, who are bound by confidentiality obligations no less stringent than these prior to any disclosure. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; providing that the receiving Party shall give reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and shall assist the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or Court does not relieve the receiving Party of its confidentiality obligations with respect to any other party.

19.4 Except as to the confidentiality of trade secrets, these confidentiality restrictions and obligations will terminate five (5) years after the expiration or termination of the Contract, unless the law requires a longer period. Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party all documents, notes and other tangible materials representing the disclosing Party's Confidential Information or Proprietary Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

19.5 For the purposes of this Section only, "Confidential Information" does not include protected health information or individually identifiable information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other privacy statutes or regulations. The access, use and disclosure of Protected Health Information is referenced below in Section 24, and shall be governed by a Business Associate Protected Health Information Disclosure Agreement, which shall be executed by the parties if CONTRACTOR will create, receive, maintain, use, or transmit Protected Health Information in performing services under this Contract.

20. Record Ownership and Retention.

20.1 The originals of all letters, documents, reports, software programs and any other products and data prepared or generated for the purposes of this Contract shall be delivered to, and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records, but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

20.2 CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("Works"), and this Contract shall be deemed a transfer

to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including, but not limited to, documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

20.3 Notwithstanding the foregoing, CONTRACTOR's intellectual property ("CONTRACTOR IP") that preexists this Contract shall remain the sole and exclusive property of CONTRACTOR. CONTRACTOR shall not incorporate any CONTRACTOR IP into the Works that would limit CalOptima's use of the Works without CalOptima's written approval. To the extent that CONTRACTOR incorporates any CONTRACTOR IP into the Works, CONTRACTOR hereby grants to CalOptima a non-exclusive, irrevocable, perpetual, worldwide, royalty-free license to use and reproduce the CONTRACTOR IP to the extent required to fully utilize the Works.

20.4 CONTRACTOR acknowledges and agrees that, notwithstanding any provision herein to the contrary, CalOptima's Intellectual Property ("CalOptima IP") in the information, documents and other materials provided to CONTRACTOR shall remain the sole and exclusive property of CalOptima. Any information, documents or materials provided by CalOptima to CONTRACTOR pursuant to this Contract and all copies thereof (including without limitation CalOptima IP, Proprietary Information and Confidential Information, as these terms are defined in Section 19) shall upon the earlier of CalOptima's request or the expiration or termination of this Contract be returned to CalOptima.

20.5 For purposes of this Section, Intellectual Property shall mean patents, copyrights, trademarks, trade secrets, and other proprietary information.

21. Patent and Copyright Infringement. In lieu of any other warranty by CalOptima or CONTRACTOR against infringement, statutory or otherwise, it is agreed that CONTRACTOR shall indemnify, hold harmless and defend, at its expense, any suit against CalOptima based on a claim that any item furnished under this Contract, or the normal use or sale thereof, infringes on any United States letters patent, patent, trademark, copyright, or other intellectual property right, and shall pay costs and damages finally awarded in any such suit, provided that CONTRACTOR is notified in writing of the suit and given authority, information, and assistance at CONTRACTOR's expense for the defense of the suit. CONTRACTOR, at no expense to CalOptima, shall obtain for CalOptima the right to use and sell said item, or shall substitute an equivalent item acceptable to CalOptima and extend this patent indemnity thereto.

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

23. Business Associate Protected Health Information Disclosure Agreement. CONTRACTOR agrees to and shall enter into a Business Associate Protected Health Information Disclosure Agreement with CalOptima, with a Security Requirements Attachment for DHCS Data and Protected Health Information/Personal Information (PHI/PI) if CONTRACTOR will create, receive, maintain, use, or transmit DHCS data or PHI/PHI, which agreement shall be incorporated herein by this reference. CONTRACTOR acknowledges and agrees that CalOptima reserves the right to modify the Business Associate Protected Health Information Disclosure Agreement at any time should such modification be required by applicable law or regulation.

24. Confidentiality of Member Information.

24.1 CONTRACTOR and its employees, agents, or subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

24.2 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by CONTRACTOR or its Subcontractors, CONTRACTOR:

24.2.1 Will not use any such information for any purpose other than carrying out the express terms of this Contract;

24.2.2 Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law;

24.2.3 Will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under; and

24.2.4 Will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose.

24.3 CONTRACTOR agrees to complete a CalOptima Medi-Cal Data Access Agreement, which is attached hereto as Exhibit D and incorporated herein by this reference. All materials covered under this Medi-Cal Data Access Agreement shall be designated confidential, to the extent permitted by California law.

25. Offshore Performance.

25.1 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.

25.2 CONTRACTOR shall complete, sign, and return Exhibit H, entitled "Attestation Concerning the Use of Offshore Subcontractors," which is attached hereto and incorporated herein by this reference, and shall submit an executed Offshore Subcontractor Attestation no less than annually thereafter.

25.3 CONTRACTOR acknowledges that CalOptima requires CONTRACTOR to obtain approval from it of CONTRACTOR's use of any offshore subcontractor whereby offshore subcontractor will have access to any type of confidential CalOptima Member information, including, but not limited to, protected health information. CONTRACTOR represents and warrants that it has disclosed to CalOptima any and all such offshore subcontractors within Exhibit H and that it has obtained CalOptima's written approval to use such offshore subcontractors prior to the effective date of this Contract.

25.4 Any new 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's Purchasing Department 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.

25.5 Unless specifically stated otherwise in this Contract, the restrictions of this Section do not apply to indirect or "overhead" services, or services that are incidental to the performance of the Contract.

25.6 The provisions of this Section apply to work performed by subcontractors at all tiers.

26. Medicare Advantage Program. Medicare Advantage Program requirements are not applicable under this Contract.

27. Time is of the Essence. Time is of the essence in performance of this Contract.

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

29. Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, the party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments, as may be necessary to perform the objectives of this Contract.

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

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

32. Notices. All notices required or permitted under this Contract and all communications regarding the interpretation of the terms of this Contract, or changes thereto, shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices

shall be effective when first received at the following addresses set forth below. Any party whose address changes shall notify the other party in writing.

To CONTRACTOR:	To CalOptima:
G.A. Food Services of Pinellas County, LLC	CalOptima
12200 32nd Court N.	505 City Parkway West
St. Petersburg, FL. 33716	Orange, CA 92868
Attention: Debra Silvers, Esq	Attention: Maria Medina, CPPB

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

34. Unavoidable Delays.

34.1 If the delivery of services under this Contract should be unavoidably delayed, CalOptima's Purchasing Department shall extend the time for completion of the Contract for the determined number of days of excusable delay. A delay is unavoidable only if the delay was not reasonably expected to occur in connection with, or during CONTRACTOR's performance, and was not caused directly or substantially by acts, omissions, negligence, or mistakes of CONTRACTOR, CONTRACTOR's subcontractors, or their agents, and was substantial and in fact caused CONTRACTOR to miss delivery dates, and could not adequately have been guarded against by contractual or legal means. Delays caused by CalOptima will be sufficient justification for delay of services, and CONTRACTOR shall be allowed a day-for-day extension.

34.2 CONTRACTOR shall notify CalOptima's Purchasing Department as soon as CONTRACTOR has, or should have, knowledge that an event has occurred that will delay deliveries. Within five (5) working days, CONTRACTOR shall confirm such notice in writing, furnishing as much detail as is available.

34.3 CONTRACTOR agrees to supply, as soon as such data is available, any reasonable proof that is required by CalOptima's Purchasing Department to make a decision on any request for extension. CalOptima's Purchasing Department shall examine the request and any documents supplied by CONTRACTOR and shall determine if CONTRACTOR is entitled to an extension and the duration of such extension. CalOptima's Purchasing Department shall notify CONTRACTOR of this decision in writing. It is expressly understood and agreed that CONTRACTOR shall not be entitled to damages or compensation, and shall not be reimbursed for losses on account of delays resulting from any cause under this provision.

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

36. Attorneys' Fees. Should either party to this Contract institute any action or proceeding to enforce or interpret this Contract or any provision hereof, or for damages by reason of any alleged breach of this Contract, otherwise arising under this Contract, or for a declaration of rights hereunder, the prevailing party in any such action or proceeding shall be entitled to receive from the other party all costs and expenses,

including, without limitation, reasonable attorneys' fees incurred by the prevailing party in such action or proceeding.

37. Entire Agreement. This Contract, including all exhibits and documents incorporated by reference and all Contract Documents referenced in Section 1 herein, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

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

39. Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power, or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof, or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

40. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 et seq.) (the "Public Records Act"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless they are exempt from disclosure under the provisions of the Public Records Act. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the Public Records Act. In the event that CONTRACTOR discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the Public Records Act that are not so marked. In the event CalOptima receives a request under the Public Records Act that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees, and any costs awarded to the person or entity that sought the CONTRACTOR marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR marked material (collectively referred to for purposes of this Section as "Public Records Act Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

41. Audit Disclosure. Pursuant to California Government Code Section 8546.7, if this Contract is over ten thousand dollars ($10,000), it is subject to examination and audit of the State Auditor, at the request of CalOptima, or as part of any audit of CalOptima, for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract or its attachments, CONTRACTOR agrees that, during the term of this Contract and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period.

42. Debarment and Suspension Certification.

42.1 By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable Federal suspension and debarment regulations.

42.2 By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

42.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

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

42.2.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph 42.2.2 herein;

42.2.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

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

42.2.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

42.3 If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima.

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

42.5 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.

43. Lobbying Restrictions and Disclosure Certification.

43.1 Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.

43.2 Certification and Disclosure Requirements.

43.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Exhibit E, Part 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made,

and will not make, any payment prohibited by Paragraph 43.3of this provision. Exhibit E is attached hereto and incorporated herein by this reference.

43.2.2 Each recipient shall file a disclosure (in the form set forth in Exhibit E, Part 2, entitled "Certification Regarding Lobbying") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 43.3 of this provision if paid for with appropriated funds.

43.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 43.2.2herein. An event that materially affects the accuracy of the information reported includes:

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

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

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

43.2.3.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 43.2.1of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

43.2.3.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 43.2.1of this provision. That person shall forward all disclosure forms to CalOptima Purchasing Manager.

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

44. Air and Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR § 15.5. CONTRACTOR agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 et seq.), as amended.

45. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Prohibited Interest, Warranties, Compensation, Confidentiality, Indemnification, Duty to Defend, Ownership of Records and Documents, Record Retention, Audit Disclosure, California Public Records Act, Patent and Copyright Infringement, Governing Law, and this Section.

46. Severability. If any section, subsection or provision of this Contract, or any Contract Documents incorporated into this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall not be affected thereby.

47. 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.

48. Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties to this Contract. Nothing in this Contract is intended to confer upon any Party other than the Parties hereto or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

49. 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.

50. Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

[Remainder of page left intentionally blank. Signatures on following page]

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. 22-10268 on the day and year last shown below.

GA Foods	CalOptima
By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

If CONTRACTOR is a corporation, two officer signatures or a Corporation Resolution or Corporate Seal is required.

Exhibit A

SCOPE OF WORK

A. OBJECTIVE

CONTRACTOR shall offer a fresh produce delivery program so CalOptima Community Network (CCN) Medi-Cal members can cook healthy and nutritious meals to manage their diabetic conditions.

Along with physician activity, nutrition and attention to food insecurity are important parts of a healthy lifestyle when managing diabetes. Following a healthy meal plan can help members keep their blood sugar in their target range. Therefore, CalOptima is planning to include a fresh produce delivery into our new multidisciplinary diabetes mellitus (DM) program to support an appropriate meal plan, based on a recommended American Diabetes Association diet, for our members with intermediate to poorly controlled diabetes (e.g., HbA1c >= 8%).

Fresh produce means fruits and vegetables that have not been processed in any manner.

Estimated eligible members: 2,600 - 3,000 members with diabetes

Eligible members will receive fresh produce delivered to their homes (in Orange County, California) twice per month following engagement in the program.

The CONTRACTOR must offer a variety of fresh produce options so members can select or customize fruits/vegetables based on their preference.

This is a two-year pilot program, and the tentative anticipated go live date is by quarter four of 2021.

B. CONTRACTOR'S RESPONSIBILITIES

CONTRACTOR shall:

1. Prepare and deliver fresh produce boxes in sufficient quantity and quality within the time frame agreed to with CalOptima and/or members.

2. Maintain appropriate and current state and/or local certification demonstrating adequate fresh produce preparation facilities and transportation resources.

3. Cooperate in any member satisfaction survey which CalOptima's DM program may choose to undertake.

4. As part of their proposal, the Offeror shall submit the following:

    a. Certificate of Insurance as cited in the Sample Contract.
    b. Comprehensive general liability
    c. Automobile liability insurance
    d. Workers' compensation certificate
    e. Copy of Health Inspection Report and Copy of Seal provided by Orange County Health Department
    f. Emergency preparedness plan

Delivery/Hours of Operation

- The CONTRACTOR must be able to deliver a fresh produce box to eligible members twice per month.
- The CONTRACTOR must be able to allow members to choose their delivery days.
- The CONTRACTOR must demonstrate proof of fresh produce delivery and provide data to CalOptima that includes a member's (or household member's) signature.

- The CONTRACTOR must provide a customer service line dedicated to our members.
- The CONTRACTOR must provide a point of contact for CalOptima who shall be available during CalOptima's normal business hours, excluding federal and state designated holidays, to receive inquiries by telephone or email.

Sanitation/Safety

- The CONTRACTOR will warrant that all food shall be fresh, clean, wholesome upon delivery, and prepared in properly equipped facilities under modern sanitary conditions in accordance with the best industry practice.
- All items shall be free from decay, discoloration, foreign matter, and shall pass through metal detection before packaging. Boxes shall be clean, sound, compact, sturdy, and sealed.
- The CONTRACTOR must have a process to address member satisfaction issues related to food delivery delays, decay or quality of produce.
- All products shall bear visible freshness code dates and shall meet industry standards for remaining shelf-life upon delivery to the members.

Nutrition Information

- The CONTRACTOR is required to provide complete product information sheets for all fresh produce items included in the proposal, indicating pack size, weight per unit, and nutritional analysis within 30 days of contract award.
- Product information sheets may be submitted in either hard copy or in electronic format.

CalOptima's Sign-Up Process

The CONTRACTOR must have the ability to ensure the safe handling of sensitive data including member's Protected Health Information (PHI). Proposals must include a description of the Offeror's ability to ensure the appropriate handling of this information, the security tools in place, and security policies and procedures.

The CONTRACTOR shall understand CalOptima's tentative member sign-up process and support CalOptima meeting this process goal.

After having consultations with a Primary Care Provider (PCP), CalOptima Pharmacist and CalOptima Registered Dietician (RD), CalOptima will identify and inform an eligible member that they can participate in a fresh produce delivery program. After receiving a list of eligible members, the CONTRACTOR shall work with CalOptima to determine specific delivery/member engagement turnaround times.

Payments (Monthly Invoices)

The CONTRACTOR shall provide a monthly detailed invoice for fresh produce delivered to member's home. Invoice to include the following information (examples):

- Member name (may also include member Client Identification Number [CIN])
- Date of delivery
- Time of delivery
- Replacement of items (if any)
- Contract/Purchase Order Number

Performance Measures:

Performance and progress monitoring will be performed quarterly and conducted by the CalOptima DM Program leadership. Performance measures or outcome measures shall be met for the CONTRACTOR to be considered in compliance.

The CONTRACTOR shall:

- Maintain environmental health inspections in good standing.
- Changes in fresh produce (if any) submitted no less than one week prior to next delivery.

- Ensure monthly approval of fresh produce by the CONTRACTOR's dietitian or nutritionist and CalOptima RD prior to finalizing fresh produce options.
- Deliver fresh produce at the scheduled time (if there is any delay expected, the CONTRACTOR shall notify members of any delivery delays in advance.)

C. CALOPTIMA RESPONSIBILITIES

- CalOptima will submit required member information to the CONTRACTOR to process fresh produce deliveries to eligible members.
- CalOptima shall maintain and provide a current point of contact for any inquiries by the CONTRACTOR.
- Some members may use CalOptima's Interpreter Services when interacting with the CONTRACTOR. CalOptima provides Interpreter Services as needed to accommodate members' requests. CalOptima's Interpreter Services are available for members at no cost. For calls other than English and cannot be answered by a bilingual staff, a CONTRACTOR must support and work with CalOptima's Interpreter Services for various languages and dialects.
- CalOptima shall provide monitoring and oversight of the CONTRACTOR services.
- CalOptima will make payment to the CONTRACTOR within thirty (30) business days from receipt of an invoice of services provided by the CONTRACTOR under this contract.

Exhibit B

PAYMENT

A. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR for fees and expenses in accordance with the provisions of this Exhibit and subject to the maximum cumulative payment obligations specified below.

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

C. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 22-10268; 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.

D. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that CalOptima's maximum cumulative payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed Four Million Nine Hundred Forty-Eight Thousand Six Hundred Eight Dollars ($4,948,608), including all amounts payable to CONTRACTOR for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract.

E. Rates, as defined below, are acknowledged to include CONTRACTOR's base labor rates, overhead and profit. 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. CalOptima shall not pay CONTRACTOR for time spent traveling. "Contractor may adjust the rate annually based upon the (12) twelve-month average of the Consumer Price Index (CPI) for "Food Away From Home and proof of increase, and if extenuating circumstances arise in the marketplace, the Parties agree to negotiate in good faith additional rate increases."

Latin Box	**Quantity/Lbs.**	**Box Price:**
Poblano	0.5 lb.	$47.35 per delivery produce box
Cauliflower	1 each	
Potato	1.5 lbs.	
Iceberg Lettuce	1 each	
Navel Orange	1 lb.	

Latin Box	Quantity/Lbs.	Box Price:
Mexican Squash	1 lb.	
Roma	1 lb.	
Bell Pepper	1 lb.	
White Onion	0.5 lb.	
Lime	0.5 lb.	
Tomatillos	1 lb.	
Nopales	1 lb.	
Jalapeno Pepper or Yellow Chile	0.5 lb	

Diabetic Box	Quantity/Lbs.	Box Price:
Roma Tomato	1.5 lb.	$47.35 per delivery produce box
Red apple	4 ct.	
Carrot	1 lb.	
Cauliflower	1 each	
Cello Lettuce	1 each	
Oranges	2 lbs.	
Butternut Squash	1 each	
Celery	1 each	
Romaine	1 each	
Onion	0.5 lb.	
Potato	1.5 lb.	
Zucchini Squash	1 lb.	
Green Bell	1 lb.	
Broccoli	2 each	
Cucumber	2 each	

Standard Box	Quantity/Lbs.	Box Price:
Roma	1 lb.	$47.35 per delivery produce box
Red apple	4 ct.	
Carrot	1 lb.	
Cauliflower	1 each	
Cantaloupe	1 each	
Cello Lettuce	1 each	
Oranges	2 lbs.	
Celery	1 each	
Romaine	1 each	
Onion	0.5 lb.	
Zucchini Squash	1 lb.	
Green Bell	1 lb.	
Broccoli	1 each	
Cucumber	2 each	

F. All produce boxes listed above are subject to change, based upon freshness, seasonality, quality, availability, and member satisfaction. Like substitutions of comparable value and weight do not require prior approval. (Ex: one stone fruit - (i.e. plum/peach), citrus fruit - (i.e. orange/grapefruit) or berry - (i.e. strawberry/blackberry) for another, one cruciferous vegetable - (i.e. broccoli/cauliflower, leafy green - (i.e. iceberg/romaine), root vegetable - (i.e. sweet potato/russet potato) for another, one legume - black bean/pinto bean for another). In the event substitutions constituting more than 20% of box contents are necessary and are dissimilar in nature, CalOptima shall review and provide written approval prior to these changes being implemented, which approval will not be unreasonably withheld.

G. CONTRACTOR shall provide CalOptima members grocery variety in the form of new seasonal box options with estimated quantity and weight indicated and the same rate listed above. CalOptima shall review new seasonal menus and provide written approval prior to delivery of seasonal boxes, which approval will not be unreasonably withheld.

Exhibit B-1

Not applicable for this Contract

Exhibit C

Not applicable for this Contract

Exhibit D

MEDI-CAL DATA ACCESS AGREEMENT

As a condition of obtaining access to information concerning procedures or other data records utilized/maintained by the Department of Health Care Services and CalOptima, G.A. Food Services of Pinellas County, LLC, dba GA Foods, including any and all individual employees and agents, agrees not to divulge any information obtained in the course of completion of this Contract to any unauthorized persons.

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

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

CONTRACTOR further agrees that this Medi-Cal Data Access Agreement shall remain in full force and effect after the termination of this Contract.

By: _____ Date: _____

Print Name: _____

Title: _____

Exhibit E
Part 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that :

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____	_____
Name of Contractor	Printed Name of Person Signing for Contractor
_____	_____
Contract/Grant Number	Signature of Person Signing for Contractor
_____	_____
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

Exhibit E

Part 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: ☐a. contract ☐b. grant ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	2. Status of Federal Action: ☐a. bid/offer/application ☐b. initial award ☐c. post-award	3. Report Type: ☐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:	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*): (*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: Print Name: Title: Telephone No.: Date:	
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL	

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Exhibit E

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 for this Contract

Exhibit G

Not applicable for this Contract

CalOptima
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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:	

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:	Title:
Email:	Phone #:
Signature:	Date:

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

Exhibit I

Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: _____

Business Entity Type: _____
(*Sole Proprietorship, Partnership, LLC, California Corporation, etc.*)

Business Address: _____

City:_____ State:_____ Zip:_____

Business Phone:_____ Email: :_____

President: _____ Contact Person:_____

Person(s) Signing Contract & Title: :_____

*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 %
_____	_____
_____	_____
_____	_____
_____	_____

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

_____ _____
Authorized Signature Date

_____
Name and Title

Exhibit J

Not applicable for this Contract

Exhibit K

Not applicable for this Contract

Exhibit L

Not applicable for this Contract

Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

16. Consider Authorizing Amendments for All OneCare Health Network Contracts Except AltaMed Health Services Corporation, ARTA Western California Inc., Monarch Healthcare A Medical Group Inc., and Talbert Medical Group P.C. to Extend the Contracts, Extend the Allocation of Non-Part D CMS Capitation, and Align the Corrective Action Plan Section of the Contracts with Current Policy

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Michelle Laughlin, Executive Director Network Operations, (657) 900-1116

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend all OneCare health network contracts except AltaMed Health Services Corporation (AltaMed), ARTA Western California Inc. (ARTA), Monarch Healthcare A Medical Group Inc. (Monarch), and Talbert Medical Group P.C. (Talbert) as follows:

1. Extend the health network contracts through December 31, 2022;
2. Extend allocation of non-Part D CMS Capitation through the end of calendar year 2022; and
3. Align the Corrective Action Plan section of the contracts with current policy

Background

Each year, the Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage (MA) Plans, including CalOptima, to submit an annual bid in order to participate in the Medicare program for the upcoming calendar year. In the annual bid, the MA Plan includes a projection of the following year's rates and costs, set based on the previous year's encounter and other data that is analyzed and provided by an independent third-party consultant. CMS contracts with the MA Plans for participation in the Medicare program following approval of their respective benefit offerings for the new year. At its May 2021 meeting, the CalOptima Board of Directors (Board) authorized submission of the OneCare bid for Calendar Year 2022. This bid has been accepted by CMS.

Discussion

Contract Extensions

CalOptima's contracts with its OneCare health networks are renewed annually at the beginning of each calendar year, pending Board approval. CalOptima contracts with AMVI Prospect Medical Group, Family Choice Medical Group Inc., Noble Community Medical Associates Inc. of Mid-Orange County, and United Care Medical Group Inc. for OneCare, all on a Shared Risk basis. These contracts expire on December 31, 2021. Therefore, staff is seeking authorization to extend the above-named OneCare health network contracts through December 31, 2022.

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Allocation of Non-Part D CMS Capitation

The allocation of the non-Part D capitation is tied to covering the full scope of the OneCare benefit design, including, for example, co-payments. It is contingent on the annual bid to extend CalOptima's contract with CMS for the OneCare program. This non-Part D allocation is renewed annually, expiring at the end of each calendar year. Staff recommend amending all OneCare health network contracts except AltaMed, ARTA, Monarch, and Talbert to extend this allocation through the end of calendar year 2022.

Align Corrective Action Plan Section of the Contract with Current Policy

CalOptima Policy HH.2005 "Corrective Action Plan" serves as a guideline for addressing Corrective Action Plans (CAPs) issued by CalOptima's Office of Compliance. Previously there was a 30-calendar day period allowed for the internal department or First Tier, Downstream, and Related Entities to respond to a CAP. As a result of policy updates, this response time has been modified to 14 calendar days. Staff recommend amending all OneCare health network contracts except AltaMed, ARTA, Monarch, and Talbert to align the corrective action plan section of the contract with current policy

Fiscal Impact

The CalOptima Fiscal Year (FY) 2021-22 Operating Budget approved by the Board on June 3, 2021, incorporated total OneCare Shared Risk Group health network capitation expenses of $6.9 million. The recommended action to extend the existing health network contracts through June 30, 2022, is a budgeted item, with no additional anticipated fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2022, through December 31, 2022, as related to the contract extensions, in the CalOptima FY 2022-23 Operating Budget.

The recommended action to amend the OneCare Shared Risk Group contracts related to CAP response time is operational in nature, with no anticipated fiscal impact beyond what was incorporated in the CalOptima FY 2021-22 Operating Budget.

Rationale for Recommendation

The recommended contract amendments are intended to ensure that the contractual relationships with all OneCare health networks are maintained and that contracts are aligned with current policy.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated November 5, 2020: Consider Authorizing Extension and Amendments to the OneCare Health Network Contracts
3. Previous Board Action dated October 3, 2019: Consider Authorizing Amendments to the OneCare Physician Medical Group Share Risk Contracts
4. CalOptima Policy & Procedure HH.2005, Corrective Action Plan
5. Proposed OneCare Health Network Contract Amendment

/s/ Richard Sanchez — *10/28/2021*
Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West Ste. 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave.	Cypress	CA	90630
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
12. Consider Authorizing Extension and Amendments to the OneCare Health Network Contracts

Contact
Michelle Laughlin, Executive Director Network Operations (657) 900-1116

Recommended Actions
Authorize the Chief Executive Officer with the assistance of Legal Counsel, to amend the OneCare Health Network contracts to extend the contract through December 31, 2021 and to address modified and additional terms.

Background & Discussion

Contract Extension
Each year, the Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage (MA) Plans, including CalOptima, to submit an annual bid in order to participate in the Medicare program for the upcoming year. In the annual bid, the MA Plan includes a projection of the following year's rates and costs, set based on previous year's encounter and other data, analyzed and provided by an independent third-party consultant. CMS contracts with the MA Plans for participation in the Medicare program, following approval of their benefit offerings for the new year. At the May 2020 Board meeting, the CalOptima Board of Directors authorized submission of the OneCare (OC) bid for calendar year 2021. The bid has been accepted by CMS.

CalOptima's contracts with its OneCare Health Networks are renewed on an annual basis, pending Board approval. CalOptima contracts with 11 health networks for OneCare, all on a Shared Risk basis. Contracts with each of these Health Networks currently expire on December 31, 2020. To maintain member access to care, staff is seeking Board authorization to extend these Contracts through December 31, 2021. In addition to extending the term, the amendment to the Health Network contracts will address the following issues:

Division of Financial Responsibility (DOFR)
Staff seeks authorization to implement changes to the DOFR, including reimbursement for Methadone Clinic services. Methadone Clinic services will be reimbursable by CalOptima as a Medicare-covered service.

Change Timeframe for Other Contract Terminations
Staff seeks authorization to amend the timeframe for termination without cause notice from 120 days to 180 days. This change allows for a more appropriate time frame related to activities involved with a termination including, but not limited to, reassignment of members, issuing new ID cards, member education, and operational system related changes.

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Allocation of Non-Part D CMS Capitation section

The allocation of the non-Part D capitation is tied to covering the full scope of the OneCare benefit design, for example copayments. It is contingent on the annual bid to extend CalOptima's contract with CMS for the OneCare program. This non-Part D allocation is renewed annually, expiring at the end of each Calendar Year. Staff recommends extending this allocation through the end of calendar 2021

Fiscal Impact

The CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020, included OneCare Share Risk Group (OC SRG) Health Network capitation expenses of $5.2 million. The recommended action to extend the existing Health Network contracts through June 30, 2021, is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2021, through December 31, 2021, as related to the contract extension in the CalOptima FY 2021-22 Operating Budget.

The recommended action to amend the OC SRG Health Network contracts to amend contract language is budget neutral. The addition of language related to the termination without cause provision is operational in nature with no additional fiscal impact beyond what was incorporated in the CalOptima FY 2020-21 Operating Budget. The proposed update to the DOFR for methadone clinic services is not anticipated to have a material impact to CalOptima's financials.

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OC members is maintained, and that contracts are aligned with current operational procedures.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Previous Board Action dated October 3, 2019; "Consider Authorizing Amendments to the OneCare Physician Medical Group Shared Risk Contracts"

/s/ Richard Sanchez — *10/28/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI/Prospect Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western California, Inc.	1665 Scenic Ave Dr., #100	Costa Mesa	CA	92626
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Monarch Healthcare, A Medical Group, Inc.	11 Technology Dr.	Irvine	CA	92618
Talbert Medical Group, P.C.	1665 Scenic Ave Dr., Ste #100	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, #400	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates of Mid-Orange County	10855 Business Center Dr. Ste. C	Cypress	CA	90630

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
19. Consider Authorizing Amendments to the OneCare Physician Medical Group Shared Risk Contracts

Contact
Michelle Laughlin, Executive Director Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the OneCare Shared Risk Physician Medical Group (PMG) Contracts with AltaMed Health Services Corporation, AMVI/Prospect Medical Group, ARTA Western California Inc., Talbert Medical Group, Family Choice Medical Group Inc., Monarch Health Plan Inc., Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Talbert Medical Group P.C., and United Care Medical Group Inc. to:

1. Extend the term of the PMG Contracts through December 31, 2020.
2. Include language related to the Merit-based Incentive Payments System (MIPS) program.

Background and Discussion
CalOptima is required to submit an annual bid to Centers for Medicare & Medicaid services (CMS) for the OneCare program. At the May 2019 meeting, the CalOptima Board of Directors authorized submission of the OneCare bid for calendar year 2020. The bid has been accepted by CMS. CalOptima contracts with eight PMGs for OneCare. Each of these Contracts currently expire on December 31, 2019. Staff is seeking Board authorization to extend these Contracts through December 31, 2020.

For dates of service beginning January 1, 2019, and beyond, and in accordance with CalOptima Policies, Physician Groups are required to implement the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. MIPS provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Funding for the program is included in standard monthly capitation, with no supplemental monies being disbursed to the Health Networks. Staff is seeking Board authorization to include language in OneCare PMG Contracts supporting the provision of incentive payments for non-contracted, MIPS-eligible providers, providing covered services.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect health network capitation expenses of $5.3 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The recommended action to renew the existing health network contracts through June 30, 2020, is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extension in future operating budgets.

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Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the OneCare provider network.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Action
2. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
3. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
4. CMS Release of 2019 MIPS Payment Adjustment Data File

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

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AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI/Prospect Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
ARTA Western California, Inc.	1665 Scenic Ave Dr, Suite 100	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Talbert Medical Group, P.C.	1665 Scenic Avenue, Suite 100	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

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- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
19. Consider Authorizing Amendments to the OneCare Physician Medical Group Shared Risk Contracts

Contact
Michelle Laughlin, Executive Director Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the OneCare Shared Risk Physician Medical Group (PMG) Contracts with AltaMed Health Services Corporation, AMVI/Prospect Medical Group, ARTA Western California Inc., Talbert Medical Group, Family Choice Medical Group Inc., Monarch Health Plan Inc., Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Talbert Medical Group P.C., and United Care Medical Group Inc. to:

1. Extend the term of the PMG Contracts through December 31, 2020.
2. Include language related to the Merit-based Incentive Payments System (MIPS) program.

Background and Discussion
CalOptima is required to submit an annual bid to Centers for Medicare & Medicaid services (CMS) for the OneCare program. At the May 2019 meeting, the CalOptima Board of Directors authorized submission of the OneCare bid for calendar year 2020. The bid has been accepted by CMS. CalOptima contracts with eight PMGs for OneCare. Each of these Contracts currently expire on December 31, 2019. Staff is seeking Board authorization to extend these Contracts through December 31, 2020.

For dates of service beginning January 1, 2019, and beyond, and in accordance with CalOptima Policies, Physician Groups are required to implement the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. MIPS provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Funding for the program is included in standard monthly capitation, with no supplemental monies being disbursed to the Health Networks. Staff is seeking Board authorization to include language in OneCare PMG Contracts supporting the provision of incentive payments for non-contracted, MIPS-eligible providers, providing covered services.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect health network capitation expenses of $5.3 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The recommended action to renew the existing health network contracts through June 30, 2020, is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extension in future operating budgets.

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Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the OneCare provider network.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Action
2. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
3. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
4. CMS Release of 2019 MIPS Payment Adjustment Data File

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Attachment to October 3, 2019 Board of Directors Meeting – Agenda Item 19

AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI/Prospect Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
ARTA Western California, Inc.	1665 Scenic Ave Dr, Suite 100	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Talbert Medical Group, P.C.	1665 Scenic Avenue, Suite 100	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

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- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

Policy:	HH.2005Δ
Title:	**Corrective Action Plan**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/ Richard Sanchez 12/07/2020*
Effective Date:	11/01/1998
Revised Date:	12/03/2020

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE
- ☐ Administrative

I. PURPOSE

This policy defines the requirements for CalOptima and its First Tier, Downstream, and Related Entities (FDRs) for development and submission of an Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) for areas of non-compliant performance, as identified by CalOptima's Office of Compliance.

II. POLICY

A. CalOptima's Office of Compliance shall conduct Auditing, operational Monitoring, and investigations of internal CalOptima departments and its FDRs to ensure compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements related to CalOptima programs.

B. CalOptima's Office of Compliance may require that an internal department or FDR develop an ICAP or CAP response based on the identified area(s) of non-compliance.

C. CalOptima's Office of Compliance shall require CalOptima internal departments and FDRs to bring their operations into full compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements, which CalOptima or its regulators have identified as non-compliant, within time frames established by CalOptima's Office of Compliance.

D. An internal department or FDR shall develop, submit, and take corrective action under an approved ICAP or CAP response in the time and manner required by CalOptima's Office of Compliance.

1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP or CAP request may lead to further action.

2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP, or CAP, request may lead to further action. CalOptima may impose Sanctions for the underlying non-compliant performance that gave rise to the ICAP or CAP request, or the failure to develop, submit, and meet the requirements of the ICAP or CAP request, in accordance with CalOptima Policy HH.2002Δ: Sanctions.

III. PROCEDURE

A. Basis for an ICAP or CAP

1. CalOptima's Office of Compliance shall routinely Monitor performance metrics, conduct routine, or focused, Audits, and conduct ongoing Monitoring and investigations of reported non-compliance for internal departments, or FDRs, through a variety of mechanisms.

    a. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of Audits conducted by federal and state regulatory agencies, including, but not limited to the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Managed Health Care (DMHC).

    b. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of an ICAP/CAP request, or other corrective action, that CalOptima receives from a federal or state regulatory agency that is directly related to the operations of an internal department or FDR.

2. In the event that CalOptima's Office of Compliance determines an internal department, or FDR, has failed to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements, the Office of Compliance may issue an ICAP, or CAP request, to address the problem. CalOptima's Office of Compliance shall coordinate its efforts with CalOptima's Human Resources Department in the event that an ICAP or CAP potentially warrants Employee disciplinary action.

B. ICAP and CAP Issuance and Requirements

1. CalOptima's Office of Compliance shall utilize a standardized ICAP and CAP request template.

2. Non-compliance with specific requirements that have the potential to cause significant Member harm, or place CalOptima's accreditation, participation, and/or contractual status with regulatory agencies in jeopardy will require an ICAP response.

    a. If the finding requires an ICAP request, as determined by CalOptima's Office of Compliance, the internal department or FDR is required to cease non-compliant activities within two (2) business days of receiving the ICAP request.

    b. The internal department or FDR shall provide a written response within three (3) business days of receiving an ICAP request, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the ICAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima's Office of Compliance.

3. A CAP request is the result of material non-compliance with specific requirements that does not rise to the level of an ICAP request.

    a. The internal department or FDR is required to respond to the CAP request within fourteen (14) calendar days. CalOptima's Compliance Officer or Designee may authorize extensions to this timeline on a case-by-case basis. Following the acceptance of the CAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima's Office of Compliance.

4. An ICAP or CAP response shall include the following elements:

a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training, and systems that failed;

b. Steps taken to resolve the deficiency;

c. Steps taken to avoid reoccurrence;

d. Method for implementation and completion of ICAP response or CAP response;

e. Individual(s) responsible for implementation of the ICAP response or CAP response;

f. An attestation by the internal department or FDR conveying a plan to remedy its identified deficiencies; and

g. ICAP response or CAP response completion date(s), as applicable.

C. Unacceptable Resolution to an ICAP or CAP

1. If the resolution to the deficiency is unacceptable or the internal department or FDR fails to respond, CalOptima's Office of Compliance shall issue a written notice to the internal department or the FDR, which shall include:

a. A summary of previous outreach and required action(s);

b. An explanation of why that the resolution was not acceptable, or why a response was not received;

c. A revised response timeline of two (2) business days for an ICAP;

i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or Designee.

d. A revised response timeline of five (5) business days for a CAP;

i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or Designee.

e. Explain the possible consequences, specific to the nature of the issue and degree of completeness in accordance with CalOptima Policy HH.2002Δ: Sanctions;

f. Possibility of escalating to the department's Chief, or the FDR's Chief Executive Officer (CEO) or their Designee; and

g. Possibility of referral to the Audit & Oversight Committee and the Compliance Committee.

D. Acceptable Resolution with ICAP or CAP Requirements

1. A response may be accepted once all requirements outlined in Section III.B.4. of this Policy are fulfilled. If an ICAP or CAP response requires Monitoring or a focused Audit, the ICAP or CAP response shall not be closed until the remediation(s) implemented have been validated by the Office of Compliance and demonstrate that the issue will not recur.

a. A response may be accepted and closed simultaneously if Monitoring or a focused Audit is not required.

2. If the resolution to the deficiency is deemed acceptable by CalOptima's Compliance Officer or Designee, CalOptima's Office of Compliance may issue a written notification of acceptance, which shall include:

   a. An acknowledgement of acceptance;

   b. A description of follow up actions which shall include, but is not limited to:

      i. Submission of finalized documentation; and/or

      ii. Focused Audit, as described in Section III.E. of this Policy; and/or

      iii. Monitoring, as deemed appropriate by CalOptima's Office of Compliance, and as described in Section III.F. of this Policy.

3. If the resolution to the deficiency is accepted and deemed sufficient by CalOptima's Compliance Officer or Designee, CalOptima's Office of Compliance shall issue a written notification of closure, which shall include:

   a. An acknowledgement of closure;

   b. The effective date of closure; and

   c. Consequences of repeat deficiencies.

E. Focused Audits

1. CalOptima's Office of Compliance may conduct a focused Audit of an internal department or FDR to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima's Office of Compliance shall notify the internal department or FDR of the scope, Audit period, and Audit deliverables that shall be required to complete the focused Audit.

3. CalOptima's Office of Compliance may continue to Monitor and/or Audit an internal department or FDR for performance of issues and/or functions related to the ICAP or CAP request.

F. Monitoring Period

1. CalOptima's Office of Compliance may conduct Monitoring of the internal department's or FDR's resolution to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima's Office of Compliance shall Monitor the resolution for a predetermined time frame, as established by CalOptima's Office of Compliance.

3. CalOptima's Office of Compliance shall notify the internal department, or FDR, of the scope, Monitoring period, and deliverables that shall be required to complete the Monitoring.

4. CalOptima's Office of Compliance may continue to Monitor and/or Audit an internal department's or FDR's performance of issues and/or functions related to the ICAP or CAP request.

G. Failure to Maintain Adequate Resolution

1. If during the Monitoring period or the focused Audit the internal department or FDR fails to maintain the remedies in place, CalOptima's Office of Compliance may issue the internal department or FDR an ICAP or CAP request, as appropriate.

2. If an ICAP request is issued, the internal department or FDR shall be required to resolve the issue within two (2) business days from the re-issuance of the finding.

   a. Extensions to this timeline may be authorized on a case-by-case basis by the Compliance Officer, or Designee.

3. The ICAP request shall require the information as described in Section III.B.4. of this Policy.

H. ICAP and CAP Tracking and Reporting

1. CalOptima's Office of Compliance shall track all CAP and ICAP requests issued utilizing a standardized tool.

2. CalOptima's Office of Compliance shall report the status of all CAP/ICAP requests to the Audit & Oversight Committee and the Compliance Committee.

3. In the event that CalOptima's Office of Compliance issues an ICAP request with respect to the CalOptima Medi-Cal Program, the Regulatory Affairs & Compliance Department shall report the issue to CalOptima's DHCS Contract Manager for Medi-Cal within three (3) business days of issuance.

4. If CalOptima's internal department, or FDR, has repeat deficiencies, the issue(s) shall be reported to the Audit & Oversight Committee and the Compliance Committee by the Office of Compliance for further action.

IV. ATTACHMENT(S)

A. ICAP/CAP Request Template

V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy HH.2002Δ: Sanctions
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Department of Health Care Services (DHCS) All Plan Letter 17-004: Subcontractual Relationships and Delegation
H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9

J. Title 22, California Code of Regulations (CCR), §51301 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
08/02/2018	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1998	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	10/01/2002	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Effective	08/01/2005	MA.9104	Corrective Action Plan	OneCare
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	08/01/2008	MA.9104	Corrective Action Plan	OneCare
Revised	04/01/2013	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare
Revised	04/01/2014	MA.9104	Corrective Action Plan	OneCare
Revised	12/01/2014	MA.9104	Corrective Action Plan	Cal MediConnect OneCare PACE
Revised	09/01/2015	HH.2005	Corrective Action Plan	Medi-Cal
Revised	09/01/2015	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	08/02/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Audit & Oversight Committee	A subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in the AOC charter.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier Entities and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
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.
Employee	For purposes of this policy, any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDRs)	First Tier Entity: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program. Downstream Entity: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services. Related Entity: Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two-thousand five-hundred dollars ($2,**500)** during a contract period.

Term	Definition
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Immediate Corrective Action Plan (ICAP) Request	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	A beneficiary who is enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a First Tier Entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

AMENDMENT {XXXX} TO
MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICE AGREEMENT

THIS AMENDMENT {XXXXX} TO THE MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICE AGREEMENT ("Amendment {XXXXX}") is effective as of January 1, 2022, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and {_____} ("Physician Group"), with respect to the following facts:

RECITALS

A. CalOptima and Physician Group have entered into a Medicare Advantage Physician Group Service Agreement (Contract), whereby Physician Group provides items and services to certain Medicare beneficiaries enrolled in the Medicare Advantage Program operated by CalOptima.

B. CalOptima and Physician Group desire to amend this Contract to extend the term of the Contract, revise the Corrective Action Plan time frame and extend the additional allocation of funds in accordance with the formula.

NOW, THEREFORE, the parties agree as follows:

1. Section 12.1 "Term of the Contract" shall be deleted in its entirety and replaced with the following:

   "12.1 **Term of Contract.** This Contract will commence on _____and will remain in effect until December 31, 2022."

2. Section 12.2.1 "Corrective Action Plan (CAP)" shall be deleted in its entirety and replaced with the following:

   "12.2.1 **Corrective Action Plan (CAP)** CalOptima may require a CAP if it receives a substantiated complaint or grievance related to the Physician Group or any Downstream Entities" non-compliance with statutory, regulatory, contractual, policy or other requirements in accordance with the CAP timing, content and other requirements of CalOptima's corrective action plan and other applicable policies."

3. Section 1.2 of Attachment B, shall be deleted in its entirety and replaced with the following:

   "1.2 For the period of January 1, 2018, through December 31, 2022, CalOptima shall pay an additional amount of (x) dollars per Enrollee per month, to be allocated in accordance with the formula contained in this Section 1, above."

4. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS THEREOF, CalOptima and {name of HN here} have executed this Amendment { #}.

FOR PHYSICIAN GROUP:	FOR CALOPTIMA:
SIGNATURE	SIGNATURE
PRINT NAME	PRINT NAME
TITLE	TITLE
DATE	DATE

Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

17. Consider Authorizing Amendments to the AltaMed Health Services Corporation OneCare Health Network Contract to Extend the Contract, Extend the Allocation of Non-Part D CMS Capitation and Align the Corrective Action Plan Section of the Contract with Current Policy

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Michelle Laughlin, Executive Director Network Operations, (657) 900-1116

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the AltaMed Health Services Corporation (AltaMed) OneCare health network contract as follows:

1. Extend the health network contracts through December 31, 2022;
2. Extend allocation of non-Part D CMS Capitation through the end of calendar year 2022; and
3. Align the Corrective Action Plan section of the contracts with current policy

Background

Each year, the Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage (MA) Plans, including CalOptima, to submit an annual bid in order to participate in the Medicare program for the upcoming calendar year. In the annual bid, the MA Plan includes a projection of the following year's rates and costs, set based on the previous year's encounter and other data that is analyzed and provided by an independent third-party consultant. CMS contracts with the MA Plans for participation in the Medicare program following approval of their respective benefit offerings for the new year. At its May 2021 meeting, the CalOptima Board of Directors (Board) authorized submission of the OneCare bid for Calendar Year 2022. This bid has been accepted by CMS.

Discussion

Contract Extensions

CalOptima's contracts with its OneCare health networks are renewed annually at the beginning of each calendar year, pending Board approval. CalOptima contracts with AltaMed on a Shared Risk basis. This contract expires on December 31, 2021. Therefore, staff is seeking authorization to extend AltaMed's OneCare health network contract through December 31, 2022:

Allocation of Non-Part D CMS Capitation

The allocation of the non-Part D capitation is tied to covering the full scope of the OneCare benefit design, including, for example, co-payments. It is contingent on the annual bid to extend CalOptima's contract with CMS for the OneCare program. This non-Part D allocation is renewed annually, expiring at the end of each calendar year. Staff recommend amending AltaMed's OneCare health network contract to extend this allocation through the end of calendar year 2022.

Align Corrective Action Plan Section of the Contract with Current Policy

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CalOptima Policy HH.2005 "Corrective Action Plan" serves as a guideline for addressing Corrective Action Plans (CAPs) issued by CalOptima's Office of Compliance. Previously there was a 30-calendar day period allowed for the internal department or First Tier, Downstream, and Related Entities to respond to a CAP. As a result of policy updates, this response time has been modified to 14 calendar days. Staff recommend amending AltaMed's OneCare health network contract to align the corrective action plan section of the contract with current policy

Fiscal Impact

The CalOptima Fiscal Year (FY) 2021-22 Operating Budget approved by the Board on June 3, 2021, incorporated total OneCare Shared Risk Group health network capitation expenses of $6.9 million. The recommended action to extend the existing health network contracts through June 30, 2022, is a budgeted item, with no additional anticipated fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2022, through December 31, 2022, as related to the contract extensions, in the CalOptima FY 2022-23 Operating Budget.

The recommended action to amend the OneCare Shared Risk Group contracts related to CAP response time is operational in nature, with no anticipated fiscal impact beyond what was incorporated in the CalOptima FY 2021-22 Operating Budget.

Rationale for Recommendation

The recommended contract amendment is intended to ensure that the contractual relationship with AltaMed is maintained and that it is aligned with current policy.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated November 5, 2020: Consider Authorizing Extension and Amendments to the OneCare Health Network Contracts
3. Previous Board Action dated October 3, 2019: Consider Authorizing Amendments to the OneCare Physician Medical Group Share Risk Contracts
4. CalOptima Policy & Procedure HH.2005, Corrective Action Plan
5. Proposed OneCare Health Network Contract Amendment

/s/ Richard Sanchez — *10/28/2021*

Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
12. Consider Authorizing Extension and Amendments to the OneCare Health Network Contracts

Contact
Michelle Laughlin, Executive Director Network Operations (657) 900-1116

Recommended Actions
Authorize the Chief Executive Officer with the assistance of Legal Counsel, to amend the OneCare Health Network contracts to extend the contract through December 31, 2021 and to address modified and additional terms.

Background & Discussion

Contract Extension
Each year, the Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage (MA) Plans, including CalOptima, to submit an annual bid in order to participate in the Medicare program for the upcoming year. In the annual bid, the MA Plan includes a projection of the following year's rates and costs, set based on previous year's encounter and other data, analyzed and provided by an independent third-party consultant. CMS contracts with the MA Plans for participation in the Medicare program, following approval of their benefit offerings for the new year. At the May 2020 Board meeting, the CalOptima Board of Directors authorized submission of the OneCare (OC) bid for calendar year 2021. The bid has been accepted by CMS.

CalOptima's contracts with its OneCare Health Networks are renewed on an annual basis, pending Board approval. CalOptima contracts with 11 health networks for OneCare, all on a Shared Risk basis. Contracts with each of these Health Networks currently expire on December 31, 2020. To maintain member access to care, staff is seeking Board authorization to extend these Contracts through December 31, 2021. In addition to extending the term, the amendment to the Health Network contracts will address the following issues:

Division of Financial Responsibility (DOFR)
Staff seeks authorization to implement changes to the DOFR, including reimbursement for Methadone Clinic services. Methadone Clinic services will be reimbursable by CalOptima as a Medicare-covered service.

Change Timeframe for Other Contract Terminations
Staff seeks authorization to amend the timeframe for termination without cause notice from 120 days to 180 days. This change allows for a more appropriate time frame related to activities involved with a termination including, but not limited to, reassignment of members, issuing new ID cards, member education, and operational system related changes.

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Allocation of Non-Part D CMS Capitation section

The allocation of the non-Part D capitation is tied to covering the full scope of the OneCare benefit design, for example copayments. It is contingent on the annual bid to extend CalOptima's contract with CMS for the OneCare program. This non-Part D allocation is renewed annually, expiring at the end of each Calendar Year. Staff recommends extending this allocation through the end of calendar 2021

Fiscal Impact

The CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020, included OneCare Share Risk Group (OC SRG) Health Network capitation expenses of $5.2 million. The recommended action to extend the existing Health Network contracts through June 30, 2021, is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2021, through December 31, 2021, as related to the contract extension in the CalOptima FY 2021-22 Operating Budget.

The recommended action to amend the OC SRG Health Network contracts to amend contract language is budget neutral. The addition of language related to the termination without cause provision is operational in nature with no additional fiscal impact beyond what was incorporated in the CalOptima FY 2020-21 Operating Budget. The proposed update to the DOFR for methadone clinic services is not anticipated to have a material impact to CalOptima's financials.

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OC members is maintained, and that contracts are aligned with current operational procedures.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Previous Board Action dated October 3, 2019; "Consider Authorizing Amendments to the OneCare Physician Medical Group Shared Risk Contracts"

/s/ Richard Sanchez — *10/28/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI/Prospect Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western California, Inc.	1665 Scenic Ave Dr., #100	Costa Mesa	CA	92626
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Monarch Healthcare, A Medical Group, Inc.	11 Technology Dr.	Irvine	CA	92618
Talbert Medical Group, P.C.	1665 Scenic Ave Dr., Ste #100	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, #400	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates of Mid-Orange County	10855 Business Center Dr. Ste. C	Cypress	CA	90630

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
19. Consider Authorizing Amendments to the OneCare Physician Medical Group Shared Risk Contracts

Contact
Michelle Laughlin, Executive Director Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the OneCare Shared Risk Physician Medical Group (PMG) Contracts with AltaMed Health Services Corporation, AMVI/Prospect Medical Group, ARTA Western California Inc., Talbert Medical Group, Family Choice Medical Group Inc., Monarch Health Plan Inc., Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Talbert Medical Group P.C., and United Care Medical Group Inc. to:

1. Extend the term of the PMG Contracts through December 31, 2020.
2. Include language related to the Merit-based Incentive Payments System (MIPS) program.

Background and Discussion
CalOptima is required to submit an annual bid to Centers for Medicare & Medicaid services (CMS) for the OneCare program. At the May 2019 meeting, the CalOptima Board of Directors authorized submission of the OneCare bid for calendar year 2020. The bid has been accepted by CMS. CalOptima contracts with eight PMGs for OneCare. Each of these Contracts currently expire on December 31, 2019. Staff is seeking Board authorization to extend these Contracts through December 31, 2020.

For dates of service beginning January 1, 2019, and beyond, and in accordance with CalOptima Policies, Physician Groups are required to implement the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. MIPS provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Funding for the program is included in standard monthly capitation, with no supplemental monies being disbursed to the Health Networks. Staff is seeking Board authorization to include language in OneCare PMG Contracts supporting the provision of incentive payments for non-contracted, MIPS-eligible providers, providing covered services.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect health network capitation expenses of $5.3 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The recommended action to renew the existing health network contracts through June 30, 2020, is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extension in future operating budgets.

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Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the OneCare provider network.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Action
2. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
3. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
4. CMS Release of 2019 MIPS Payment Adjustment Data File

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

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AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI/Prospect Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
ARTA Western California, Inc.	1665 Scenic Ave Dr, Suite 100	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Talbert Medical Group, P.C.	1665 Scenic Avenue, Suite 100	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

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- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
19. Consider Authorizing Amendments to the OneCare Physician Medical Group Shared Risk Contracts

Contact
Michelle Laughlin, Executive Director Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the OneCare Shared Risk Physician Medical Group (PMG) Contracts with AltaMed Health Services Corporation, AMVI/Prospect Medical Group, ARTA Western California Inc., Talbert Medical Group, Family Choice Medical Group Inc., Monarch Health Plan Inc., Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Talbert Medical Group P.C., and United Care Medical Group Inc. to:

1. Extend the term of the PMG Contracts through December 31, 2020.
2. Include language related to the Merit-based Incentive Payments System (MIPS) program.

Background and Discussion
CalOptima is required to submit an annual bid to Centers for Medicare & Medicaid services (CMS) for the OneCare program. At the May 2019 meeting, the CalOptima Board of Directors authorized submission of the OneCare bid for calendar year 2020. The bid has been accepted by CMS. CalOptima contracts with eight PMGs for OneCare. Each of these Contracts currently expire on December 31, 2019. Staff is seeking Board authorization to extend these Contracts through December 31, 2020.

For dates of service beginning January 1, 2019, and beyond, and in accordance with CalOptima Policies, Physician Groups are required to implement the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. MIPS provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Funding for the program is included in standard monthly capitation, with no supplemental monies being disbursed to the Health Networks. Staff is seeking Board authorization to include language in OneCare PMG Contracts supporting the provision of incentive payments for non-contracted, MIPS-eligible providers, providing covered services.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect health network capitation expenses of $5.3 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The recommended action to renew the existing health network contracts through June 30, 2020, is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extension in future operating budgets.

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Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the OneCare provider network.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Action
2. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
3. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
4. CMS Release of 2019 MIPS Payment Adjustment Data File

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Attachment to October 3, 2019 Board of Directors Meeting – Agenda Item 19

AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI/Prospect Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
ARTA Western California, Inc.	1665 Scenic Ave Dr, Suite 100	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Talbert Medical Group, P.C.	1665 Scenic Avenue, Suite 100	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

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Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

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Additional Information

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FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

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File Layout

The MIPS payment adjustment data file will consist of four data elements:

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- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

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- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

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Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

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Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
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PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

Policy:	HH.2005Δ
Title:	**Corrective Action Plan**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/ Richard Sanchez 12/07/2020*
Effective Date:	11/01/1998
Revised Date:	12/03/2020

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE
- ☐ Administrative

I. PURPOSE

This policy defines the requirements for CalOptima and its First Tier, Downstream, and Related Entities (FDRs) for development and submission of an Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) for areas of non-compliant performance, as identified by CalOptima's Office of Compliance.

II. POLICY

A. CalOptima's Office of Compliance shall conduct Auditing, operational Monitoring, and investigations of internal CalOptima departments and its FDRs to ensure compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements related to CalOptima programs.

B. CalOptima's Office of Compliance may require that an internal department or FDR develop an ICAP or CAP response based on the identified area(s) of non-compliance.

C. CalOptima's Office of Compliance shall require CalOptima internal departments and FDRs to bring their operations into full compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements, which CalOptima or its regulators have identified as non-compliant, within time frames established by CalOptima's Office of Compliance.

D. An internal department or FDR shall develop, submit, and take corrective action under an approved ICAP or CAP response in the time and manner required by CalOptima's Office of Compliance.

1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP or CAP request may lead to further action.

2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP, or CAP, request may lead to further action. CalOptima may impose Sanctions for the underlying non-compliant performance that gave rise to the ICAP or CAP request, or the failure to develop, submit, and meet the requirements of the ICAP or CAP request, in accordance with CalOptima Policy HH.2002Δ: Sanctions.

III. PROCEDURE

A. Basis for an ICAP or CAP

1. CalOptima's Office of Compliance shall routinely Monitor performance metrics, conduct routine, or focused, Audits, and conduct ongoing Monitoring and investigations of reported non-compliance for internal departments, or FDRs, through a variety of mechanisms.

    a. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of Audits conducted by federal and state regulatory agencies, including, but not limited to the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Managed Health Care (DMHC).

    b. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of an ICAP/CAP request, or other corrective action, that CalOptima receives from a federal or state regulatory agency that is directly related to the operations of an internal department or FDR.

2. In the event that CalOptima's Office of Compliance determines an internal department, or FDR, has failed to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements, the Office of Compliance may issue an ICAP, or CAP request, to address the problem. CalOptima's Office of Compliance shall coordinate its efforts with CalOptima's Human Resources Department in the event that an ICAP or CAP potentially warrants Employee disciplinary action.

B. ICAP and CAP Issuance and Requirements

1. CalOptima's Office of Compliance shall utilize a standardized ICAP and CAP request template.

2. Non-compliance with specific requirements that have the potential to cause significant Member harm, or place CalOptima's accreditation, participation, and/or contractual status with regulatory agencies in jeopardy will require an ICAP response.

    a. If the finding requires an ICAP request, as determined by CalOptima's Office of Compliance, the internal department or FDR is required to cease non-compliant activities within two (2) business days of receiving the ICAP request.

    b. The internal department or FDR shall provide a written response within three (3) business days of receiving an ICAP request, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the ICAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima's Office of Compliance.

3. A CAP request is the result of material non-compliance with specific requirements that does not rise to the level of an ICAP request.

    a. The internal department or FDR is required to respond to the CAP request within fourteen (14) calendar days. CalOptima's Compliance Officer or Designee may authorize extensions to this timeline on a case-by-case basis. Following the acceptance of the CAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima's Office of Compliance.

4. An ICAP or CAP response shall include the following elements:

a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training, and systems that failed;

b. Steps taken to resolve the deficiency;

c. Steps taken to avoid reoccurrence;

d. Method for implementation and completion of ICAP response or CAP response;

e. Individual(s) responsible for implementation of the ICAP response or CAP response;

f. An attestation by the internal department or FDR conveying a plan to remedy its identified deficiencies; and

g. ICAP response or CAP response completion date(s), as applicable.

C. Unacceptable Resolution to an ICAP or CAP

1. If the resolution to the deficiency is unacceptable or the internal department or FDR fails to respond, CalOptima's Office of Compliance shall issue a written notice to the internal department or the FDR, which shall include:

a. A summary of previous outreach and required action(s);

b. An explanation of why that the resolution was not acceptable, or why a response was not received;

c. A revised response timeline of two (2) business days for an ICAP;

i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or Designee.

d. A revised response timeline of five (5) business days for a CAP;

i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or Designee.

e. Explain the possible consequences, specific to the nature of the issue and degree of completeness in accordance with CalOptima Policy HH.2002Δ: Sanctions;

f. Possibility of escalating to the department's Chief, or the FDR's Chief Executive Officer (CEO) or their Designee; and

g. Possibility of referral to the Audit & Oversight Committee and the Compliance Committee.

D. Acceptable Resolution with ICAP or CAP Requirements

1. A response may be accepted once all requirements outlined in Section III.B.4. of this Policy are fulfilled. If an ICAP or CAP response requires Monitoring or a focused Audit, the ICAP or CAP response shall not be closed until the remediation(s) implemented have been validated by the Office of Compliance and demonstrate that the issue will not recur.

a. A response may be accepted and closed simultaneously if Monitoring or a focused Audit is not required.

2. If the resolution to the deficiency is deemed acceptable by CalOptima's Compliance Officer or Designee, CalOptima's Office of Compliance may issue a written notification of acceptance, which shall include:

   a. An acknowledgement of acceptance;

   b. A description of follow up actions which shall include, but is not limited to:

      i. Submission of finalized documentation; and/or

      ii. Focused Audit, as described in Section III.E. of this Policy; and/or

      iii. Monitoring, as deemed appropriate by CalOptima's Office of Compliance, and as described in Section III.F. of this Policy.

3. If the resolution to the deficiency is accepted and deemed sufficient by CalOptima's Compliance Officer or Designee, CalOptima's Office of Compliance shall issue a written notification of closure, which shall include:

   a. An acknowledgement of closure;

   b. The effective date of closure; and

   c. Consequences of repeat deficiencies.

E. Focused Audits

1. CalOptima's Office of Compliance may conduct a focused Audit of an internal department or FDR to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima's Office of Compliance shall notify the internal department or FDR of the scope, Audit period, and Audit deliverables that shall be required to complete the focused Audit.

3. CalOptima's Office of Compliance may continue to Monitor and/or Audit an internal department or FDR for performance of issues and/or functions related to the ICAP or CAP request.

F. Monitoring Period

1. CalOptima's Office of Compliance may conduct Monitoring of the internal department's or FDR's resolution to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima's Office of Compliance shall Monitor the resolution for a predetermined time frame, as established by CalOptima's Office of Compliance.

3. CalOptima's Office of Compliance shall notify the internal department, or FDR, of the scope, Monitoring period, and deliverables that shall be required to complete the Monitoring.

4. CalOptima's Office of Compliance may continue to Monitor and/or Audit an internal department's or FDR's performance of issues and/or functions related to the ICAP or CAP request.

G. Failure to Maintain Adequate Resolution

1. If during the Monitoring period or the focused Audit the internal department or FDR fails to maintain the remedies in place, CalOptima's Office of Compliance may issue the internal department or FDR an ICAP or CAP request, as appropriate.

2. If an ICAP request is issued, the internal department or FDR shall be required to resolve the issue within two (2) business days from the re-issuance of the finding.

   a. Extensions to this timeline may be authorized on a case-by-case basis by the Compliance Officer, or Designee.

3. The ICAP request shall require the information as described in Section III.B.4. of this Policy.

H. ICAP and CAP Tracking and Reporting

1. CalOptima's Office of Compliance shall track all CAP and ICAP requests issued utilizing a standardized tool.

2. CalOptima's Office of Compliance shall report the status of all CAP/ICAP requests to the Audit & Oversight Committee and the Compliance Committee.

3. In the event that CalOptima's Office of Compliance issues an ICAP request with respect to the CalOptima Medi-Cal Program, the Regulatory Affairs & Compliance Department shall report the issue to CalOptima's DHCS Contract Manager for Medi-Cal within three (3) business days of issuance.

4. If CalOptima's internal department, or FDR, has repeat deficiencies, the issue(s) shall be reported to the Audit & Oversight Committee and the Compliance Committee by the Office of Compliance for further action.

IV. ATTACHMENT(S)

A. ICAP/CAP Request Template

V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy HH.2002Δ: Sanctions
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Department of Health Care Services (DHCS) All Plan Letter 17-004: Subcontractual Relationships and Delegation
H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9

J. Title 22, California Code of Regulations (CCR), §51301 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
08/02/2018	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1998	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	10/01/2002	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Effective	08/01/2005	MA.9104	Corrective Action Plan	OneCare
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	08/01/2008	MA.9104	Corrective Action Plan	OneCare
Revised	04/01/2013	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare
Revised	04/01/2014	MA.9104	Corrective Action Plan	OneCare
Revised	12/01/2014	MA.9104	Corrective Action Plan	Cal MediConnect OneCare PACE
Revised	09/01/2015	HH.2005	Corrective Action Plan	Medi-Cal
Revised	09/01/2015	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	08/02/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Audit & Oversight Committee	A subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in the AOC charter.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier Entities and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
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.
Employee	For purposes of this policy, any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDRs)	First Tier Entity: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program. Downstream Entity: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services. Related Entity: Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two-thousand five-hundred dollars ($2,**500)** during a contract period.

Term	Definition
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Immediate Corrective Action Plan (ICAP) Request	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	A beneficiary who is enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a First Tier Entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

AMENDMENT {XXXX} TO
MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICE AGREEMENT

THIS AMENDMENT {XXXXX} TO THE MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICE AGREEMENT ("Amendment {XXXXX}") is effective as of January 1, 2022, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and {_____} ("Physician Group"), with respect to the following facts:

RECITALS

A. CalOptima and Physician Group have entered into a Medicare Advantage Physician Group Service Agreement (Contract), whereby Physician Group provides items and services to certain Medicare beneficiaries enrolled in the Medicare Advantage Program operated by CalOptima.

B. CalOptima and Physician Group desire to amend this Contract to extend the term of the Contract, revise the Corrective Action Plan time frame and extend the additional allocation of funds in accordance with the formula.

NOW, THEREFORE, the parties agree as follows:

1. Section 12.1 "Term of the Contract" shall be deleted in its entirety and replaced with the following:

   "12.1 **Term of Contract.** This Contract will commence on _____and will remain in effect until December 31, 2022."

2. Section 12.2.1 "Corrective Action Plan (CAP)" shall be deleted in its entirety and replaced with the following:

   "12.2.1 **Corrective Action Plan (CAP)** CalOptima may require a CAP if it receives a substantiated complaint or grievance related to the Physician Group or any Downstream Entities" non-compliance with statutory, regulatory, contractual, policy or other requirements in accordance with the CAP timing, content and other requirements of CalOptima's corrective action plan and other applicable policies."

3. Section 1.2 of Attachment B, shall be deleted in its entirety and replaced with the following:

   "1.2 For the period of January 1, 2018, through December 31, 2022, CalOptima shall pay an additional amount of (x) dollars per Enrollee per month, to be allocated in accordance with the formula contained in this Section 1, above."

4. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS THEREOF, CalOptima and {name of HN here} have executed this Amendment { #}.

FOR PHYSICIAN GROUP:	FOR CALOPTIMA:
SIGNATURE	SIGNATURE
PRINT NAME	PRINT NAME
TITLE	TITLE
DATE	DATE

Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Authorizing Amendments to the OneCare Health Network Contracts for ARTA Western California Inc., Monarch Healthcare, A Medical Group Inc., and Talbert Medical Group P.C. to Extend the Contracts, Extend the Allocation of Non-Part D CMS Capitation and Align the Corrective Action Plan Section of the Contract with Current Policy

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Michelle Laughlin, Executive Director Network Operations, (657) 900-1116

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the OneCare health network contracts for ARTA Western California Inc. (ARTA), Monarch Healthcare, A Medical Group Inc. (Monarch), and Talbert Medical Group P.C. (Talbert) as follows:

1. Extend the health network contracts through December 31, 2022;
2. Extend allocation of non-Part D CMS Capitation through the end of calendar year 2022; and
3. Align the Corrective Action Plan section of the contracts with current policy

Background

Each year, the Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage (MA) Plans, including CalOptima, to submit an annual bid in order to participate in the Medicare program for the upcoming calendar year. In the annual bid, the MA Plan includes a projection of the following year's rates and costs, set based on the previous year's encounter and other data that is analyzed and provided by an independent third-party consultant. CMS contracts with the MA Plans for participation in the Medicare program following approval of their respective benefit offerings for the new year. At its May 2021 meeting, the CalOptima Board of Directors (Board) authorized submission of the OneCare bid for Calendar Year 2022. This bid has been accepted by CMS.

Discussion

Contract Extensions

CalOptima's contracts with its OneCare health networks are renewed annually at the beginning of each calendar year, pending Board approval. CalOptima contracts with ARTA, Monarch, and Talbert all on a Shared Risk basis. These contracts expire on December 31, 2021. Therefore, staff is seeking authorization to extend the OneCare health network contracts for ARTA, Monarch, and Talbert through December 31, 2022:

Allocation of Non-Part D CMS Capitation

The allocation of the non-Part D capitation is tied to covering the full scope of the OneCare benefit design, including, for example, co-payments. It is contingent on the annual bid to extend CalOptima's contract with CMS for the OneCare program. This non-Part D allocation is renewed annually, expiring at the end of each calendar year. Staff recommend amending the OneCare health network contracts for

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ARTA, Monarch, and Talbert to extend this allocation through the end of calendar year 2022.

Align Corrective Action Plan Section of the Contract with Current Policy
CalOptima Policy HH.2005 "Corrective Action Plan" serves as a guideline for addressing Corrective Action Plans (CAPs) issued by CalOptima's Office of Compliance. Previously there was a 30-calendar day period allowed for the internal department or First Tier, Downstream, and Related Entities to respond to a CAP. As a result of policy updates, this response time has been modified to 14 calendar days. Staff recommend amending the OneCare health network contracts for ARTA, Monarch, and Talbert to align the corrective action plan section of the contract with current policy

Fiscal Impact
The CalOptima Fiscal Year (FY) 2021-22 Operating Budget approved by the Board on June 3, 2021, incorporated total OneCare Shared Risk Group health network capitation expenses of $6.9 million. The recommended action to extend the existing health network contracts through June 30, 2022, is a budgeted item, with no additional anticipated fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2022, through December 31, 2022, as related to the contract extensions, in the CalOptima FY 2022-23 Operating Budget.

The recommended action to amend the OneCare Shared Risk Group contracts related to CAP response time is operational in nature, with no anticipated fiscal impact beyond what was incorporated in the CalOptima FY 2021-22 Operating Budget.

Rationale for Recommendation
The recommended contract amendments are intended to ensure that the contractual relationships with ARTA, Monarch, and Talbert are maintained and that contracts are aligned with current policy.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated November 5, 2020, "Consider Authorizing Extension and Amendments to the OneCare Health Network Contracts"
3. Previous Board Action dated October 3, 2019, "Consider Authorizing Amendments to the OneCare Physician Medical Group Share Risk Contracts"
4. CalOptima Policy & Procedure HH.2005, Corrective Action Plan
5. Proposed OneCare Health Network Contract Amendment

/s/ Richard Sanchez *10/28/2021*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
Monarch Healthcare, A Medical Group, Inc.	11 Technology Dr.	Irvine	CA	92618
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
12. Consider Authorizing Extension and Amendments to the OneCare Health Network Contracts

Contact
Michelle Laughlin, Executive Director Network Operations (657) 900-1116

Recommended Actions
Authorize the Chief Executive Officer with the assistance of Legal Counsel, to amend the OneCare Health Network contracts to extend the contract through December 31, 2021 and to address modified and additional terms.

Background & Discussion

Contract Extension
Each year, the Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage (MA) Plans, including CalOptima, to submit an annual bid in order to participate in the Medicare program for the upcoming year. In the annual bid, the MA Plan includes a projection of the following year's rates and costs, set based on previous year's encounter and other data, analyzed and provided by an independent third-party consultant. CMS contracts with the MA Plans for participation in the Medicare program, following approval of their benefit offerings for the new year. At the May 2020 Board meeting, the CalOptima Board of Directors authorized submission of the OneCare (OC) bid for calendar year 2021. The bid has been accepted by CMS.

CalOptima's contracts with its OneCare Health Networks are renewed on an annual basis, pending Board approval. CalOptima contracts with 11 health networks for OneCare, all on a Shared Risk basis. Contracts with each of these Health Networks currently expire on December 31, 2020. To maintain member access to care, staff is seeking Board authorization to extend these Contracts through December 31, 2021. In addition to extending the term, the amendment to the Health Network contracts will address the following issues:

Division of Financial Responsibility (DOFR)
Staff seeks authorization to implement changes to the DOFR, including reimbursement for Methadone Clinic services. Methadone Clinic services will be reimbursable by CalOptima as a Medicare-covered service.

Change Timeframe for Other Contract Terminations
Staff seeks authorization to amend the timeframe for termination without cause notice from 120 days to 180 days. This change allows for a more appropriate time frame related to activities involved with a termination including, but not limited to, reassignment of members, issuing new ID cards, member education, and operational system related changes.

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Allocation of Non-Part D CMS Capitation section

The allocation of the non-Part D capitation is tied to covering the full scope of the OneCare benefit design, for example copayments. It is contingent on the annual bid to extend CalOptima's contract with CMS for the OneCare program. This non-Part D allocation is renewed annually, expiring at the end of each Calendar Year. Staff recommends extending this allocation through the end of calendar 2021

Fiscal Impact

The CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020, included OneCare Share Risk Group (OC SRG) Health Network capitation expenses of $5.2 million. The recommended action to extend the existing Health Network contracts through June 30, 2021, is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2021, through December 31, 2021, as related to the contract extension in the CalOptima FY 2021-22 Operating Budget.

The recommended action to amend the OC SRG Health Network contracts to amend contract language is budget neutral. The addition of language related to the termination without cause provision is operational in nature with no additional fiscal impact beyond what was incorporated in the CalOptima FY 2020-21 Operating Budget. The proposed update to the DOFR for methadone clinic services is not anticipated to have a material impact to CalOptima's financials.

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OC members is maintained, and that contracts are aligned with current operational procedures.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Previous Board Action dated October 3, 2019; "Consider Authorizing Amendments to the OneCare Physician Medical Group Shared Risk Contracts"

/s/ Richard Sanchez — *10/28/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI/Prospect Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western California, Inc.	1665 Scenic Ave Dr., #100	Costa Mesa	CA	92626
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Monarch Healthcare, A Medical Group, Inc.	11 Technology Dr.	Irvine	CA	92618
Talbert Medical Group, P.C.	1665 Scenic Ave Dr., Ste #100	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, #400	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates of Mid-Orange County	10855 Business Center Dr. Ste. C	Cypress	CA	90630

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
19. Consider Authorizing Amendments to the OneCare Physician Medical Group Shared Risk Contracts

Contact
Michelle Laughlin, Executive Director Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the OneCare Shared Risk Physician Medical Group (PMG) Contracts with AltaMed Health Services Corporation, AMVI/Prospect Medical Group, ARTA Western California Inc., Talbert Medical Group, Family Choice Medical Group Inc., Monarch Health Plan Inc., Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Talbert Medical Group P.C., and United Care Medical Group Inc. to:

1. Extend the term of the PMG Contracts through December 31, 2020.
2. Include language related to the Merit-based Incentive Payments System (MIPS) program.

Background and Discussion
CalOptima is required to submit an annual bid to Centers for Medicare & Medicaid services (CMS) for the OneCare program. At the May 2019 meeting, the CalOptima Board of Directors authorized submission of the OneCare bid for calendar year 2020. The bid has been accepted by CMS. CalOptima contracts with eight PMGs for OneCare. Each of these Contracts currently expire on December 31, 2019. Staff is seeking Board authorization to extend these Contracts through December 31, 2020.

For dates of service beginning January 1, 2019, and beyond, and in accordance with CalOptima Policies, Physician Groups are required to implement the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. MIPS provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Funding for the program is included in standard monthly capitation, with no supplemental monies being disbursed to the Health Networks. Staff is seeking Board authorization to include language in OneCare PMG Contracts supporting the provision of incentive payments for non-contracted, MIPS-eligible providers, providing covered services.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect health network capitation expenses of $5.3 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The recommended action to renew the existing health network contracts through June 30, 2020, is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extension in future operating budgets.

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Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the OneCare provider network.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Action
2. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
3. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
4. CMS Release of 2019 MIPS Payment Adjustment Data File

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Attachment to October 3, 2019 Board of Directors Meeting – Agenda Item 19

AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI/Prospect Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
ARTA Western California, Inc.	1665 Scenic Ave Dr, Suite 100	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Talbert Medical Group, P.C.	1665 Scenic Avenue, Suite 100	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

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- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
19. Consider Authorizing Amendments to the OneCare Physician Medical Group Shared Risk Contracts

Contact
Michelle Laughlin, Executive Director Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the OneCare Shared Risk Physician Medical Group (PMG) Contracts with AltaMed Health Services Corporation, AMVI/Prospect Medical Group, ARTA Western California Inc., Talbert Medical Group, Family Choice Medical Group Inc., Monarch Health Plan Inc., Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Talbert Medical Group P.C., and United Care Medical Group Inc. to:

1. Extend the term of the PMG Contracts through December 31, 2020.
2. Include language related to the Merit-based Incentive Payments System (MIPS) program.

Background and Discussion
CalOptima is required to submit an annual bid to Centers for Medicare & Medicaid services (CMS) for the OneCare program. At the May 2019 meeting, the CalOptima Board of Directors authorized submission of the OneCare bid for calendar year 2020. The bid has been accepted by CMS. CalOptima contracts with eight PMGs for OneCare. Each of these Contracts currently expire on December 31, 2019. Staff is seeking Board authorization to extend these Contracts through December 31, 2020.

For dates of service beginning January 1, 2019, and beyond, and in accordance with CalOptima Policies, Physician Groups are required to implement the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. MIPS provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Funding for the program is included in standard monthly capitation, with no supplemental monies being disbursed to the Health Networks. Staff is seeking Board authorization to include language in OneCare PMG Contracts supporting the provision of incentive payments for non-contracted, MIPS-eligible providers, providing covered services.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect health network capitation expenses of $5.3 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The recommended action to renew the existing health network contracts through June 30, 2020, is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extension in future operating budgets.

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Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the OneCare provider network.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Action
2. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
3. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
4. CMS Release of 2019 MIPS Payment Adjustment Data File

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Attachment to October 3, 2019 Board of Directors Meeting – Agenda Item 19

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

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MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

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In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

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MIPS Adjustment File Access

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Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
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7500 Security Boulevard
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MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

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This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

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- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

Policy:	HH.2005Δ
Title:	**Corrective Action Plan**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/ Richard Sanchez 12/07/2020*
Effective Date:	11/01/1998
Revised Date:	12/03/2020

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE
- ☐ Administrative

I. PURPOSE

This policy defines the requirements for CalOptima and its First Tier, Downstream, and Related Entities (FDRs) for development and submission of an Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) for areas of non-compliant performance, as identified by CalOptima's Office of Compliance.

II. POLICY

A. CalOptima's Office of Compliance shall conduct Auditing, operational Monitoring, and investigations of internal CalOptima departments and its FDRs to ensure compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements related to CalOptima programs.

B. CalOptima's Office of Compliance may require that an internal department or FDR develop an ICAP or CAP response based on the identified area(s) of non-compliance.

C. CalOptima's Office of Compliance shall require CalOptima internal departments and FDRs to bring their operations into full compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements, which CalOptima or its regulators have identified as non-compliant, within time frames established by CalOptima's Office of Compliance.

D. An internal department or FDR shall develop, submit, and take corrective action under an approved ICAP or CAP response in the time and manner required by CalOptima's Office of Compliance.

1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP or CAP request may lead to further action.

2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP, or CAP, request may lead to further action. CalOptima may impose Sanctions for the underlying non-compliant performance that gave rise to the ICAP or CAP request, or the failure to develop, submit, and meet the requirements of the ICAP or CAP request, in accordance with CalOptima Policy HH.2002Δ: Sanctions.

III. PROCEDURE

A. Basis for an ICAP or CAP

1. CalOptima's Office of Compliance shall routinely Monitor performance metrics, conduct routine, or focused, Audits, and conduct ongoing Monitoring and investigations of reported non-compliance for internal departments, or FDRs, through a variety of mechanisms.

    a. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of Audits conducted by federal and state regulatory agencies, including, but not limited to the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Managed Health Care (DMHC).

    b. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of an ICAP/CAP request, or other corrective action, that CalOptima receives from a federal or state regulatory agency that is directly related to the operations of an internal department or FDR.

2. In the event that CalOptima's Office of Compliance determines an internal department, or FDR, has failed to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements, the Office of Compliance may issue an ICAP, or CAP request, to address the problem. CalOptima's Office of Compliance shall coordinate its efforts with CalOptima's Human Resources Department in the event that an ICAP or CAP potentially warrants Employee disciplinary action.

B. ICAP and CAP Issuance and Requirements

1. CalOptima's Office of Compliance shall utilize a standardized ICAP and CAP request template.

2. Non-compliance with specific requirements that have the potential to cause significant Member harm, or place CalOptima's accreditation, participation, and/or contractual status with regulatory agencies in jeopardy will require an ICAP response.

    a. If the finding requires an ICAP request, as determined by CalOptima's Office of Compliance, the internal department or FDR is required to cease non-compliant activities within two (2) business days of receiving the ICAP request.

    b. The internal department or FDR shall provide a written response within three (3) business days of receiving an ICAP request, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the ICAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima's Office of Compliance.

3. A CAP request is the result of material non-compliance with specific requirements that does not rise to the level of an ICAP request.

    a. The internal department or FDR is required to respond to the CAP request within fourteen (14) calendar days. CalOptima's Compliance Officer or Designee may authorize extensions to this timeline on a case-by-case basis. Following the acceptance of the CAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima's Office of Compliance.

4. An ICAP or CAP response shall include the following elements:

a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training, and systems that failed;

b. Steps taken to resolve the deficiency;

c. Steps taken to avoid reoccurrence;

d. Method for implementation and completion of ICAP response or CAP response;

e. Individual(s) responsible for implementation of the ICAP response or CAP response;

f. An attestation by the internal department or FDR conveying a plan to remedy its identified deficiencies; and

g. ICAP response or CAP response completion date(s), as applicable.

C. Unacceptable Resolution to an ICAP or CAP

1. If the resolution to the deficiency is unacceptable or the internal department or FDR fails to respond, CalOptima's Office of Compliance shall issue a written notice to the internal department or the FDR, which shall include:

a. A summary of previous outreach and required action(s);

b. An explanation of why that the resolution was not acceptable, or why a response was not received;

c. A revised response timeline of two (2) business days for an ICAP;

i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or Designee.

d. A revised response timeline of five (5) business days for a CAP;

i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or Designee.

e. Explain the possible consequences, specific to the nature of the issue and degree of completeness in accordance with CalOptima Policy HH.2002Δ: Sanctions;

f. Possibility of escalating to the department's Chief, or the FDR's Chief Executive Officer (CEO) or their Designee; and

g. Possibility of referral to the Audit & Oversight Committee and the Compliance Committee.

D. Acceptable Resolution with ICAP or CAP Requirements

1. A response may be accepted once all requirements outlined in Section III.B.4. of this Policy are fulfilled. If an ICAP or CAP response requires Monitoring or a focused Audit, the ICAP or CAP response shall not be closed until the remediation(s) implemented have been validated by the Office of Compliance and demonstrate that the issue will not recur.

a. A response may be accepted and closed simultaneously if Monitoring or a focused Audit is not required.

2. If the resolution to the deficiency is deemed acceptable by CalOptima's Compliance Officer or Designee, CalOptima's Office of Compliance may issue a written notification of acceptance, which shall include:

   a. An acknowledgement of acceptance;

   b. A description of follow up actions which shall include, but is not limited to:

      i. Submission of finalized documentation; and/or

      ii. Focused Audit, as described in Section III.E. of this Policy; and/or

      iii. Monitoring, as deemed appropriate by CalOptima's Office of Compliance, and as described in Section III.F. of this Policy.

3. If the resolution to the deficiency is accepted and deemed sufficient by CalOptima's Compliance Officer or Designee, CalOptima's Office of Compliance shall issue a written notification of closure, which shall include:

   a. An acknowledgement of closure;

   b. The effective date of closure; and

   c. Consequences of repeat deficiencies.

E. Focused Audits

1. CalOptima's Office of Compliance may conduct a focused Audit of an internal department or FDR to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima's Office of Compliance shall notify the internal department or FDR of the scope, Audit period, and Audit deliverables that shall be required to complete the focused Audit.

3. CalOptima's Office of Compliance may continue to Monitor and/or Audit an internal department or FDR for performance of issues and/or functions related to the ICAP or CAP request.

F. Monitoring Period

1. CalOptima's Office of Compliance may conduct Monitoring of the internal department's or FDR's resolution to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima's Office of Compliance shall Monitor the resolution for a predetermined time frame, as established by CalOptima's Office of Compliance.

3. CalOptima's Office of Compliance shall notify the internal department, or FDR, of the scope, Monitoring period, and deliverables that shall be required to complete the Monitoring.

4. CalOptima's Office of Compliance may continue to Monitor and/or Audit an internal department's or FDR's performance of issues and/or functions related to the ICAP or CAP request.

G. Failure to Maintain Adequate Resolution

1. If during the Monitoring period or the focused Audit the internal department or FDR fails to maintain the remedies in place, CalOptima's Office of Compliance may issue the internal department or FDR an ICAP or CAP request, as appropriate.

2. If an ICAP request is issued, the internal department or FDR shall be required to resolve the issue within two (2) business days from the re-issuance of the finding.

   a. Extensions to this timeline may be authorized on a case-by-case basis by the Compliance Officer, or Designee.

3. The ICAP request shall require the information as described in Section III.B.4. of this Policy.

H. ICAP and CAP Tracking and Reporting

1. CalOptima's Office of Compliance shall track all CAP and ICAP requests issued utilizing a standardized tool.

2. CalOptima's Office of Compliance shall report the status of all CAP/ICAP requests to the Audit & Oversight Committee and the Compliance Committee.

3. In the event that CalOptima's Office of Compliance issues an ICAP request with respect to the CalOptima Medi-Cal Program, the Regulatory Affairs & Compliance Department shall report the issue to CalOptima's DHCS Contract Manager for Medi-Cal within three (3) business days of issuance.

4. If CalOptima's internal department, or FDR, has repeat deficiencies, the issue(s) shall be reported to the Audit & Oversight Committee and the Compliance Committee by the Office of Compliance for further action.

IV. ATTACHMENT(S)

A. ICAP/CAP Request Template

V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy HH.2002Δ: Sanctions
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Department of Health Care Services (DHCS) All Plan Letter 17-004: Subcontractual Relationships and Delegation
H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9

J. Title 22, California Code of Regulations (CCR), §51301 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
08/02/2018	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1998	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	10/01/2002	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Effective	08/01/2005	MA.9104	Corrective Action Plan	OneCare
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	08/01/2008	MA.9104	Corrective Action Plan	OneCare
Revised	04/01/2013	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare
Revised	04/01/2014	MA.9104	Corrective Action Plan	OneCare
Revised	12/01/2014	MA.9104	Corrective Action Plan	Cal MediConnect OneCare PACE
Revised	09/01/2015	HH.2005	Corrective Action Plan	Medi-Cal
Revised	09/01/2015	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	08/02/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Audit & Oversight Committee	A subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in the AOC charter.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier Entities and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
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.
Employee	For purposes of this policy, any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDRs)	First Tier Entity: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program. Downstream Entity: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services. Related Entity: Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two-thousand five-hundred dollars ($2,**500)** during a contract period.

Term	Definition
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Immediate Corrective Action Plan (ICAP) Request	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	A beneficiary who is enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a First Tier Entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

AMENDMENT {XXXX} TO
MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICE AGREEMENT

THIS AMENDMENT {XXXXX} TO THE MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICE AGREEMENT ("Amendment {XXXXX}") is effective as of January 1, 2022, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and {_____} ("Physician Group"), with respect to the following facts:

RECITALS

A. CalOptima and Physician Group have entered into a Medicare Advantage Physician Group Service Agreement (Contract), whereby Physician Group provides items and services to certain Medicare beneficiaries enrolled in the Medicare Advantage Program operated by CalOptima.

B. CalOptima and Physician Group desire to amend this Contract to extend the term of the Contract, revise the Corrective Action Plan time frame and extend the additional allocation of funds in accordance with the formula.

NOW, THEREFORE, the parties agree as follows:

1. Section 12.1 "Term of the Contract" shall be deleted in its entirety and replaced with the following:

   "12.1 **Term of Contract.** This Contract will commence on _____and will remain in effect until December 31, 2022."

2. Section 12.2.1 "Corrective Action Plan (CAP)" shall be deleted in its entirety and replaced with the following:

   "12.2.1 **Corrective Action Plan (CAP)** CalOptima may require a CAP if it receives a substantiated complaint or grievance related to the Physician Group or any Downstream Entities" non-compliance with statutory, regulatory, contractual, policy or other requirements in accordance with the CAP timing, content and other requirements of CalOptima's corrective action plan and other applicable policies."

3. Section 1.2 of Attachment B, shall be deleted in its entirety and replaced with the following:

   "1.2 For the period of January 1, 2018, through December 31, 2022, CalOptima shall pay an additional amount of (x) dollars per Enrollee per month, to be allocated in accordance with the formula contained in this Section 1, above."

4. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS THEREOF, CalOptima and {name of HN here} have executed this Amendment { #}.

FOR PHYSICIAN GROUP:	FOR CALOPTIMA:
SIGNATURE	SIGNATURE
PRINT NAME	PRINT NAME
TITLE	TITLE
DATE	DATE

Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

19. Consider Authorizing Amendments to Extend the OneCare Connect Cal MediConnect Plan Health Network Contracts for All Health Networks Except AltaMed Health Services Corporation, ARTA Western California Inc., Monarch Health Plan Inc., and Talbert Medical Group P.C., and Align the Corrective Action Plan Section of the Contract with Current Policy

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Michelle Laughlin, Executive Director Network Operations, (657) 900-1116

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the OneCareConnect health network contracts for all health networks except AltaMed Health Services Corporation (AltaMed), ARTA Western California Inc. (ARTA), Monarch Health Plan Inc. (Monarch), and Talbert Medical Group P.C. (Talbert), as follows:

1. Exercise the final one-year extension option of the health network contracts agreements through December 31, 2022; and
2. Align the Corrective Action Plan section of the contract with current policy

Background

In 2014, the State launched Cal MediConnect (CMC), designed to serve members eligible for both Medicare and Medi-Cal, in a dual health plan covering medical, prescription drug, and long-term services and support. CMC was initially launched as a three-year demonstration program across eight counties in California. In Orange County, CalOptima provides health care services to CMC beneficiaries via OneCare Connect (OCC). OCC was established with authorization through a three-way contract between CalOptima, the Department of Health Care Services (DHCS), and the Centers for Medicare & Medicaid Services (CMS). The CalOptima Board of Directors (Board) initially authorized this three-way contract at its December 5, 2013, meeting, with CalOptima providing OCC benefits as of July 1, 2015.

At its September 2017 meeting, the Board authorized the execution of a new three-way contract between CalOptima, CMS and DHCS to extend OCC for an additional two years, through December 31, 2019. At its October 3, 2019, meeting, the Board authorized execution of a third three-way contract, which became effective September 1, 2019. Among key changes it included was the extension of the CMC Demonstration Period through December 31, 2022, renewable in one-year terms. With the sunsetting of the Cal MediConnect demonstration program at the end of calendar year 2022, OCC will sunset. CalOptima plans to transition all OCC members as of January 1, 2023, to OneCare (HMO SNP). This includes expanding the OneCare provider network to accommodate the increased membership that will take effect as OCC ends.

Effective July 1, 2015, CalOptima contracted with its OCC delegated health networks for an

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initial period through December 31, 2017. The Board approved an amendment for a one-year extension, to be effective January 1, 2018, with option to extend an additional year, ending December 31, 2019. The Board approved two additional amendments to extend the contract, to be effective January 1, 2020, through December 31, 2020, as well as January 1, 2021 through December 31, 2021.

Discussion

Health Network Contract Extensions

With OCC entering its third year of the three-year extension allowance for the three-way contract with DHCS and CMS, CalOptima needs to maintain its contractual relationships with the health networks providing health care services to OCC members. CalOptima contracts with the 7 health networks below for OCC, under the Shared Risk (SR), Physician Hospital Consortium (PHC), and Health Maintenance Organization (HMO) contract models.

AMVI Care Health Network (PHC, with Fountain Valley Regional Hospital)

Family Choice Medical Group, Inc (SR)
Fountain Valley Regional Hospital and Medical Center (PHC, with AMVI)
Heritage Provider Network, Inc. (HMO)
Noble Community Medical Associates, Inc. of Mid-Orange County (SR)
Prospect Health Plan, Inc. (HMO)
United Care Medical Group, Inc. (SR)

In coordination with the extension of the demonstration period, staff is seeking authorization to extend the health network contracts with the above-named entities through December 31, 2022:

Align Corrective Action Plan Section of the Contract with Current Policy

CalOptima Policy HH.2005 "Corrective Action Plan" serves as a guideline for addressing Corrective Action Plans (CAPs) issued by CalOptima's Office of Compliance. Previously there was a 30-calendar day period allowed for the internal department or First Tier, Downstream, and Related Entities to respond to a CAP. As a result of policy updates, this response time has been modified to 14 calendar days. Staff recommend amending the OCC health network contracts for all OCC health networks except AltaMed, ARTA, Monarch, and Talbert, to align the corrective action plan section of the contract with current policy

Fiscal Impact

The CalOptima Fiscal Year (FY) 2021-22 Operating Budget approved by the Board on June 3, 2021, incorporated total OCC health network capitation expenses of $146.8 million. The recommended action to extend the existing health network contracts through June 30, 2022, is a budgeted item, with no additional fiscal impact expected. Management plans to include revenue and expenses for the period of

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July 1, 2022, through December 31, 2022, as related to the proposed contract extensions, in the CalOptima FY 2022-23 Operating Budget.

The recommended action to amend the OCC Health Network contracts related to CAP response time is operational in nature, with no anticipated fiscal impact beyond what was incorporated in the CalOptima FY 2021-22 Operating Budget.

Rationale for Recommendation

The recommended contract changes are intended to ensure that the contractual relationships with all OCC health networks except AltaMed, ARTA, Monarch, and Talbert are maintained and that contracts are aligned with current policy.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated November 5, 2020: Consider Authorizing Extension of, and Amendments to, the Cal MediConnect (OneCare Connect) Health Network Contracts
3. Previous Board Action dated November 7, 2019: Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, except those associated with AltaMed Health Services Corporation, to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services
4. Previous Board Action dated November 7, 2019: Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services
5. CalOptima Policy & Procedure HH.2005: Corrective Action Plan
6. Proposed OneCare Connect Health Network Contract Amendment

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
November 5, 2020	Consider Authorizing Extension of, and Amendments to, the Cal MediConnect (OneCare Connect) Health Network Contracts		
November 7, 2019	Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, Except Those Associated with AltaMed Health Services Corporation to Extend them and		

	Incorporate Other Changes and to Amend Certain Network Contract to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services		
November 7, 2019	Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts Associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contract to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services		
November 1, 2018	Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts		
September 7, 2017	Authorize and Direct Execution of a New Three-Way Contract Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program		
December 5, 2013	Consider Participation in the Cal MediConnect Program		

/s/ Richard Sanchez *10/28/2021*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West Ste. 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave.	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
13. Consider Authorizing Extension of, and Amendments to, the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Action
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the OneCare Connect Health Network contracts to extend the term through December 31, 2021 and to address modified and additional terms.

Background
In 2014, the State launched Cal MediConnect (CMC), designed to serve members eligible for both Medicare and Medi-Cal, in a dual health plan covering medical, prescription drug, and long-term services and support. CMC was initially launched as a three-year demonstration program across eight counties in California. At the local level, CalOptima provides health care services to CMC beneficiaries in Orange County, via its OneCare Connect (OCC) program. OCC was executed with authorization through a three-way contract between CalOptima, the Department of Health Care Services (DHCS), and the Centers for Medicare & Medicaid Services (CMS). The CalOptima Board of Directors (Board) initially authorized this agreement at its December 5, 2013 meeting, with CalOptima providing OCC benefits as of July 1, 2015.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC/OCC program for an additional two years, through December 31, 2019. At its October 3, 2019 meeting, the Board authorized execution of a third Three-Way agreement, which became effective September 1, 2019. Among key changes it included the extension of the CMC Demonstration Period through December 31, 2022, renewable in one-year terms.

In support of CMC/OCC, CalOptima has contracted with its delegated Health Networks to manage health care services for OCC members as of the program's launch. At the Board's November 2018 meeting, staff received authorization to extend the Health Network contracts for one year, through December 31, 2019. On November 7, 2019, the Board authorized staff to exercise the first of three one-year (1) extension options in each of the Health Network contracts, extending them through December 31, 2020.

Discussion

Health Network Contract Extensions
With OCC entering its second year of the three-year extension granted for the Three-Way agreement with DHCS, CalOptima needs to maintain its contractual relationship with the Health Networks providing health care services to OCC members. In coordination with the extension of the

demonstration period, staff is seeking authorization to exercise a one-year extension option of the Health Networks' agreements through December 31, 2021.

Capitation Rate Change for Hospital and Shared Risk Pool Funding
Staff seeks authorization to amend the OCC Health Network contracts to adjust the Hospital capitation rates and Shared Risk Pool funding to more appropriately reflect delegated risk assigned to Health Networks, and as included in the CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020.

Division of Financial Responsibility (DOFR)
Staff seeks authorization to implement changes to the DOFR, including changing coverage of Methadone Clinic services to CalOptima Responsibility as a Medicare covered service. Additionally, Worldwide Coverage has been added as a Medicare covered service.

Change Timeframe for Termination Without Cause
Staff also seeks authorization to amend the notice period for Termination Without Cause from 120 days to 180 days. This change allows for a more appropriate time frame related to activities involved with a termination including, but not limited to, reassignment of members, issuing new ID cards, member education, and operational systems-related changes.

Fiscal Impact
The CalOptima FY 2020-21 Operating Budget approved by the Board on June 4, 2020 incorporated OCC Health Network capitation expenses of $133 million, including updated Hospital capitation rates and their associated impact to Shared Risk Pool funding. The recommended action to extend the existing Health Network contracts through June 30, 2021 is a budgeted item, with no additional fiscal impact. Management plans to include revenue and expenses for OCC for the period of July 1, 2021 through December 31, 2021, as related to the contract extensions, in the CalOptima FY 2021-22 Operating Budget.

The recommended action to amend the OCC Health Network contracts to add the recommended contract language is budget neutral. The addition of language related to the termination without cause provision is operational in nature, with no anticipated fiscal impact beyond what was incorporated in the CalOptima FY 2020-21 Operating Budget. The proposed changes to the DOFR are not anticipated to have a material impact to CalOptima's financials.

Rationale for Recommendation
The recommended contract changes are intended to ensure that the contractual relationships with the Health Networks serving CalOptima's OCC members are maintained, and that contracts are aligned with current operational procedures.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Previous Board Action dated November 7, 2019; "Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services."
3. Previous Board Action dated September 7, 2017; "Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program"
4. Previous Board Action dated November 7, 2019; "Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, except those associated with AltaMed Health Services Corporation, to Extend them and Incorporate Oher Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services"

/s/ Richard Sanchez — *10/28/2020*
Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western Medical Group	1665 Scenic Ave Dr., #100	Costa Mesa	CA	92626
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Monarch Medical Group	11 Technology Dr.	Irvine	CA	92618
Talbert Medical Group	1665 Scenic Ave Dr., Ste #100	Costa Mesa	CA	92626
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868
AltaMed Health Services	2040 Camfield Ave.	Los Angeles	CA	90040
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates	10855 Business Center Dr. Ste. C	Cypress	CA	90630
Prospect Medical Group	600 City Parkway West Ste. 800	Orange	CA	92868

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

Contact

Michelle Laughlin, Executive Director, Network Operations (714) 246-8400
Nancy Huang, Interim Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the OneCare Connect Health Network contracts with AltaMed Health Services Corporation to:

i. Extend the OneCare Connect Health Network contract through and including December 31, 2020;
ii. Add any necessary language provisions required based on the Three-Way Cal MediConnect contract (Three-Way Agreement) between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements, including language reflecting changes related to the Merit-based Incentive Payments System (MIPS) program; and
iii. Clarify access standards for prenatal care.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (CMC) OneCare Connect beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

Cal MediConnect was launched in 2014 as a three-year demonstration program implemented across eight counties. OneCare Connect (OCC) was launched July 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated Health Networks to manage services to the network's assigned membership.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019. At its November 2018 meeting, the Board authorized CalOptima to extend the Health Network contracts for one year through December 31, 2019.
At its October 3, 2019 meeting, the Board authorized execution of the newest version of the three-way agreement, which became effective September 1, 2019. Among the key changes of the new agreement was extension of the Cal MediConnect demonstration period through, December 31, 2022, in one-year

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terms. In accordance with this change, staff is seeking authorization to extend the Health Network agreements for an additional year through December 31, 2020.

Discussion

Language Provisions; Agreement with CMS and DHCS

Contract amendments will be required to include provisions to address technical revisions and any other new/revised requirements from the new Three-Way Agreement that are applicable to the OneCare Connect Health Networks. To be in compliance with the most current version of the Three-Way Agreement received from DHCS, effective September 1, 2019, staff seeks authority to amend OneCare Connect Health Network contracts to ensure contracted OCC Health Networks ensure that providers are enrolled with DHCS as Medicaid providers consistent with all Medicaid enrollment requirements. Other changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Merit-based Incentive Payment Systems (MIPS)

In accordance with the Medicare Access and CHIP Reauthorization Act of 2015 Quality Payment Program memorandum and CalOptima Policies and Procedures, Health Networks implemented the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. This provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Payment to health networks is contingent upon annual receipt of their provider payment adjustment confirmation report, which identifies and reports all claims qualifying for MIPS payment adjustments. Health Networks are required to submit their adjustment reports on an annual basis, starting July 2020. For dates of service January 1, 2019 through December 31, 2019, payment year is 2021. Staff seeks authority to amend contracts to include language in support of the MIPS payment adjustments to the OCC Health Networks to remain in compliance with this CMS-mandated program.

Access Standards for Prenatal Care

As it relates to maternity services and access standards for prenatal care, the OneCare Connect Contract will be updated to be consistent with CalOptima's Medi-Cal Health Network contracts. The Medi-Cal Health Network contract language ensures that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for prenatal services and ensure that Physician Groups have a process in place for follow-up on Member missed appointments.

Summary of Recommendations

Staff seeks Board authorization to amend the Health Network agreements as needed to extend and add any necessary language provisions required by the Three-Way Agreement, and to include language supporting the provision for MIPS, ACOG and GEMT.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect Health Network capitation expenses of $131 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The

recommended action to renew the existing Health Network contracts through June 30, 2020 is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extensions, in the CalOptima FY 2020-21 Operating Budget.

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OCC members is maintained, allows flexibility to modify OCC Health Network contracts as needed based on CalOptima's Three-Way Agreement with DHCS and CMS, support CalOptima's payment obligations under the MIPS program, and ensure access standards for prenatal care are aligned with the most current ACOG standards and guidelines.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated December 5, 2013; Consider Participation in the Cal MediConnect Program
3. Board Action dated September 7, 2017; Authorize and Direct Execution of a New Three-Way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program
4. Board Action dated November 1, 2018; Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts
5. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
6. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
7. CMS Release of 2019 MIPS Payment Adjustment Data File

/s/ Michael Schrader — *10/30/2019*

Authorized Signature — **Date**

AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. C. Consider Participation in the Cal MediConnect Program

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400
Patti McFarland, Chief Financial Officer, (714) 246-8400

Recommended Actions
Consider the following required actions to participate in the Cal MediConnect Program:
1. Authorize and Direct the Chairman of the Board of Directors to Execute the Three-Way Agreement between the California DHCS, CMS and CalOptima for Cal MediConnect, subject to the interim final rates that will not harm the financial viability of CalOptima and reasonable and expected requirements related to operations and reporting;
2. Authorize and Direct the Chairman of the Board of Directors to Execute the California Department of Social Services' (CDSS) Contract for In-Home Supportive Services (IHSS);
3. Approve Revisions Related to Cal MediConnect to CalOptima's Fiscal Year (FY) 2013-14 Budget; and
4. Authorize the CEO to develop and/or update policies necessary to meet Cal MediConnect participation requirements and implement the program's benefit set.

Background
In June 2012, Senate Bill 1008 (2012) and SB 1036 (2012) authorized the Coordinated Care Initiative (CCI). The CCI is composed of two (2) key components that will work in tandem to improve care coordination and integration.

1. Cal MediConnect: No sooner than April 1, 2014, the state will begin a three (3) year federal-state demonstration program in eight (8) counties. Individuals with Medicare and Medi-Cal (i.e., dual eligible beneficiaries) will receive coordinated medical, behavioral health, institutional long-term care, and home and community based services through a single Medi-Cal managed care plan. The participating counties are: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside, and San Bernardino.

2. Managed Medi-Cal Long-Term Supports and Services (MLTSS): No sooner than April 1, 2014, all Medi-Cal beneficiaries, including dual eligible beneficiaries, will receive long-term services and supports and Medi-Cal wrap-around benefits through a Medi-Cal managed care plan. MLTSS includes institutional long-term care, Community Based Adult Services, Multipurpose Senior Services Program, and IHSS.

   As a County Organized Health System (COHS), CalOptima already serves dual eligible beneficiaries, and provides Medi-Cal wrap-around services to members. In addition, pursuant to SB 94 (2013), DHCS separated the MLTSS component from the Cal MediConnect program. Medi-Cal managed care plans will provide MLTSS as a Medi-Cal benefit to all enrollees even if Cal Medi-Connect does not move forward.

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DHCS initially proposed to implement Cal MediConnect no sooner than January 1, 2014. However, DHCS revised the timeline several times to accommodate ongoing negotiations with CMS and to resolve other implementation issues. On August 13, 2013, DHCS formally announced that Cal MediConnect will begin no sooner than April 1, 2014. Initial enrollment will occur on a passive enrollment basis for a twelve (12) month period, based on the eligible beneficiary's birthday month.

CalOptima's FY 2013-14 Operating Budget projected an increased enrollment of 27,000 members from the Cal MediConnect program through June 30, 2014. Staff will make a downward adjustment to the membership projection due to the delayed implementation date, and anticipates approximately 3,700 members will be passively enrolled each month. Staff will implement strategies to minimize the opt-out rate of the Cal MediConnect program.

The Demonstration Years for the Cal MediConnect program are as follows:

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

On May 3, 2012, your Board approved a pre-implementation budget for the CCI of $373,994 to proceed with the application process to participate in the program. The funds were used to support travel and training, consultant fees, limited term staffing, and outreach and engagement. The budget was for the period of May 3, 2012, through August 31, 2012.

On January 3, 2013, your Board approved additional funding to continue pre-implementation planning for the CCI of $615,000 for a total of $988,994. The funds were used to support professional fees and staffing. To date, approximately ninety-five percent (95%) of the pre-implementation funds have been spent. Based on Board approval, staff has completed all state and federal applications and additional requests, including but not limited to:

Key Deliverables	Date
DHCS Request for Solutions	February 23, 2012
CMS Capitated Financial Alignment Demonstration application	May 23, 2012
Proposed Model of Care	June 29, 2012
Proposed Medication Management Therapy Program	May 6, 2013
Proposed Part D Formulary	May 31, 2013
Proposed Plan Benefit Package	June 3, 2013
Revised Health Service Delivery Tables for Network Validation	June 26, 2013

Key steps and milestones for the Cal MediConnect program are as follows:

Key Steps and Milestones	Date
Finalize Memorandum of Understanding (MOU) (CMS and DHCS)	Executed March 27, 2013

Key Steps and Milestones	Date
Develop final capitation rates	Ongoing since April 23, 2013
Conduct joint readiness assessments (CMS and DHCS)	Initiated March 2013 and ongoing through December 2013 - Desk Review: April 19, 2013 - On-site visit: July 25-26, 2013 - Remote Systems Testing: October 21, 2013 - Network Validation: October 28, 2013 - Pre-Enrollment Validation: November 20, 2013 - Final Readiness report to be issued mid-December 2013
Execute MOUs with relevant county agencies	Completed in July and August 2013
Sign Three-Way contract	December 13, 2013 (electronic signature) December 16, 2013 (hard copy signature)
Sign CDSS contract for IHSS services	Mid-December 2013 (anticipated)
Finalize Plan Benefit Package in CMS system	Mid-December 2013
Implement Cal MediConnect	No sooner than April 1, 2014

On June 6, 2013, your Board approved CalOptima's FY 2013-14 Operating Budget. Staff clarified that the operating budget did not include infrastructure and implementation funding for the Duals Demonstration (i.e., the Cal MediConnect program), and that Staff would present the budget as a separate Board action.

Discussion

Both DHCS and CMS are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of Cal MediConnect. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted, as noted above, from the prior dates shared with the Board in previous meetings. Staff participated in the on-site readiness review July 25-26, 2013.

The next key step is for CalOptima to sign the Three-Way Agreement with CMS and DHCS. Recently, DHCS notified participating plans that the final date by which CMS will require execution of the Agreement is December 10, 2013. Plans, including CalOptima, received the "final" Three-Way Agreement on November 6, 2013 and were advised that they would not be able to negotiate changes to the Agreement. Although the document contains a number of terms that are currently in other program agreements, this was the first time that plans received the document which contains new Cal MediConnect program requirements, Plans had approximately one week to review the document and submit a list of "significant concerns" to the Agreement. DHCS held a conference call with plans on November 20, 2013 to discuss the comments plans submitted. On the call, the DHCS provided clarification on certain terms, but essentially reiterated that the "final" version was, in fact, final. CMS and DHCS issued interim final rates in late October for plans' thirty (30) day review. Additionally, DHCS has indicated that rates may be subject to additional minor revisions prior to the final execution of the Agreement.

Three-Way Cal MediConnect Agreement

The Agreement between DHCS, CMS, and CalOptima outlines the respective obligations for each party to implement the Cal MediConnect program in Orange County. The Agreement contains provisions for CMS

and DHCS to evaluate CalOptima's performance as a Cal MediConnect participating plan, including adherence to federal Medicare and Medicaid laws.

Below are some areas within the Agreement that will have a significant operational and financial impact:

Requirement / Area of Concern	Impact
Benefits and funding streams	The Agreement reflects continued fragmentation of Medicare and Medi-Cal benefits, services, and funding streams will pose operational challenges. Full integration will likely not occur until year 2 of the demonstration.
Care coordination	The Agreement includes extensive care coordination requirements that conflict with the existing Medicare requirements for a plan's Model of Care are included in the Agreement. Specifically, the ten (10) day timeframe to develop Individualized Care Plans (ICPs) for members after completion of the Health Risk Assessment (HRA) is insufficient.
Rate dispute process	The Agreement excludes rates from the dispute process. Requiring participating plans to waive their legal rights to dispute a rate that may be unreasonable or actuarially unsound is particularly problematic in year 2 and 3 of the demonstration.
Quality withholds	There is a lack of specific information on the quality withhold metrics, and how plans will be measured for purposes of earning back the withheld amount based on performance. The agreement lacks a process for plans to provide meaningful input on the performance metrics that will be tied to the quality withholds for each Demonstration year.
IHSS	Plans are required to assume full risk for IHSS provider payments (i.e., wages and benefits, such as health insurance). The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December. CalOptima Board of Directors would likely have to make a "go / no-go" decision on the 3-way contract for Cal MediConnect in December without the opportunity to review the CDSS contract.
After-hours call capacity	Plans cannot leverage current 24-hour Nurse Advice Lines to meet the after-hours call capacity requirement as the after-hours call service needs to be staffed either by a physician or an appropriate licensed professional under his or her supervision.

Requirement / Area of Concern	Impact
Pending contracts and regulatory guidance	The Agreement incorporates requirements to comply with unissued CMS/DHCS guidance. These references in the Agreement are broad and are not limited to indicating that the guidance will do no more than interpret current requirements under State and Federal laws.
Advisory Committee	Requires the formation of a new Advisory Committee to the Board of Directors, which must consist of not more than eleven (11) people, and no less than fifty percent (50%) of the membership of the advisory committee shall be individuals who are users of personal assistance paid for through public or private funds or recipients of IHSS services.

Other issues related to the Three-Way Agreement for Cal MediConnect include:

- Lack of specific information on IHSS;
  - Data sharing issues with the California Department of Social Services (CDSS) for IHSS; and
  - Contract terms for agreement with CDSS. The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December.

- Reporting requirements not yet specified (e.g., network adequacy, performance measures).

Revisions to CalOptima's FY 2013-14 Implementation, Operating, and Capital Budgets
Staff is submitting revisions to the FY 2013-14 Implementation, Operating, and Capital Budget to the BOD for approval with assumptions based on currently available information.

Proposed Budget 1/1/14 – 6/30/14			
	Implementation	**Operational**	**Total**
Average Monthly Enrollment	N/A	7,118	7,118
Revenue	$0	$43,130,331	$43,130,331
Medical Costs	$2,845,316	$38,414,385	$41,259,701
Administrative Costs	$2,879,267	$4,069,166	$6,948,433
Operating Income/(Loss)	($5,724,583)	$646,780	($5,077,803)
Medical Loss Ratio (MLR)	N/A	89.1%	95.7%
Administrative Loss Ratio (ALR)	N/A	9.4%	16.1%
Capital – Hardware/Software			$1,100,000

Enrollment Assumptions:
- Begins April 1, 2014 with an estimated 3,680 members
- Assumes a pre-enrollment opt-out rate of 20% and disenrollment rate of 5%

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- CY 2014 enrollment will consist of FFS Medicare membership, since Medicare Advantage enrollees are allowed to stay with existing plan through Dec 2014

Revenue Assumptions:
- Bases Medicare rates on draft rates provided in October 2013
- Bases Medi-Cal rates on draft rates provided on November 20, 2013
- Estimates total revenue of $2,019.74 per member per month
- Medicare Part A/B and Part D rates utilizes a base rate and applies a risk adjustment factor (similar to OneCare revenue)
- Medi-Cal rate is a blended rate of four population cohorts: LTC, HCBS High, HCBS Low, and Community Well
- Adjusts rates for savings targets that escalate from 1.4% to 5.5% over the next three and a half years

Medical Cost Assumptions:
- Assumes an average provider capitation rate of 37.5% of Medicare Part A/B premium
- Uses current OneCare medical utilization and unit cost rates as a proxy
- Assumes an MLR of 85.3% on prescription drug benefits
- Assumes an MLR of 90.3% on Medi-Cal wrap-around benefits
- Excludes supplemental benefits with the exception of mental health and transportation services
- Includes program guidelines that require higher levels of Case Management and Health Services
- Estimates eighty-two (82) FTE's are scheduled over the remainder of the year

Administrative Cost Assumptions:
- Includes implementation costs of $5.7 million to prepare the organizations processes, policies, and staff for a targeted go-live date of April 1, 2014
- Program guidelines specify staffing requirements, such as Compliance and Customer Service
- Estimates sixty-three (63) FTE's are scheduled over the remainder of the year
- First twelve (12) months of the program will require higher than standard level of cost for initial items such as member and provider mailings as well as staff recruitment and training. These costs are staged in to occur approximately three (3) months prior to the member enrollment.

Capital Assumptions:
- Includes hardware and software required to support the increase in staffing and projected membership population

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
CCMS (Medical Database)	$ 222,300	20%
Facets Upgrades	204,300	19%
Backup Environment	67,240	6%
Core Infrastructure	58,020	5%
Data Warehouse	43,000	4%

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Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
Misc (Network Costs)	505,140	46%
Total	$ 1,100,000	100%

The Proposed budget includes hardware, software, and professional fees.

Next Steps:
After receipt and review of the Three-Way Agreement and analysis of the interim final rates, Staff recommends the BOD to authorize the Chairman to execute the Three-Way Agreement for CalOptima to participate in Cal MediConnect.

Concurrently, Staff will continue to prepare for the implementation of Cal MediConnect and Managed MLTSS.

Approval of the proposed actions and the Board Chair's execution of the three-way agreement with CMS and DHCS will commit CalOptima to participating in the Cal MediConnect Program.

Fiscal Impact
As outlined above, the proposed revisions to the CalOptima FY 2013-14 Implementation and Operating Budget reflect a deficit of $5.1 million and a Capital Budget of $1.1 million.

Rationale for Recommendation
The DHCS proposal to implement the CCI aligns with CalOptima's long standing commitment to better integrate acute and long term care services. This integration initiative provides CalOptima an opportunity to work with community stakeholders to design a system that fully integrates the administrative and financial responsibilities for Medi-Cal and Medicare covered services and achieve its acute and long term care integration goals.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *11/27/2013*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

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policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

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Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

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Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

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APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

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Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

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- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: January 8, 2019

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer R. Shapiro, Acting Director, Medicare Plan Payment Group

SUBJECT: **Release of 2019 MIPS Payment Adjustment Data File**

The Centers for Medicare & Medicaid Services (CMS) has uploaded to the Health Plan Management System (HPMS) the Merit-based Incentive Payment System (MIPS) Payment Adjustment Data File for payment year 2019. Medicare Advantage organizations (MAOs) can use the information in the file to determine the amount of the MIPS payment adjustment that applies to their payments for Medicare Part B covered professional services furnished by out-of-network MIPS eligible clinicians.

For guidance on when and how the MIPS payments apply to MAOs' payments to MIPS eligible clinicians, please see the April 27, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments" and the November 8, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance."

File Access

The 2019 MIPS Payment Adjustment Data File has been added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). After navigating to the "Incentive Payments" section, a user may download the file by selecting "MIPS Payment Adjustment Data File" under Step One, "2019" under Step Two, and "Download" under Step Three.

Due to the sensitivity of some of the information provided in the file, only the MAO's Medicare Compliance Officer will be able to access and download it. The Compliance Officer must be a registered HPMS user in order to obtain the file.

Identifying the Applicable MIPS Adjustment Percentage

The MIPS Payment Adjustment Data File consists of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)

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- MIPS adjustment percentage
- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see the attached Appendix.

An MAO can identify the applicable MIPS adjustment percentage for a MIPS eligible clinician by matching the clinician's billing TIN/NPI combination to a TIN/NPI combination in the MIPS Payment Adjustment Data File. If an exact match for the billing TIN/NPI combination does not appear in the data file, the MAO should determine whether the NPI appears in combination with another TIN and, if so, apply the MIPS adjustment percentage associated with that TIN/NPI combination. If the NPI appears in more than one TIN/NPI combination in the data file, the MAO should apply the MIPS adjustment percentage for the TIN/NPI combination that results in the greatest total payment amount.

Additional Information

If you encounter technical difficulties when downloading the MIPS Payment Adjustment Data File from HPMS, you may contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028.

If the "Incentive Payments" hyperlink does not appear in the HPMS Data Extract Facility, you must send a request for additional access to hpms_access@cms.hhs.gov. Please note that information in the MIPS Payment Adjustment Data File is considered sensitive and may require additional levels of approval.

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

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Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

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APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

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Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

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policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

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Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

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Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

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APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, except those associated with AltaMed Health Services Corporation, to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

Contact

Michelle Laughlin, Executive Director, Network Operations (714) 246-8400
Nancy Huang, Interim Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the OneCare Connect:

1. Health Network contracts with AMVI Care Health Network, ARTA Western California, Inc., Talbert Medical Group, P.C., Family Choice Medical Group Inc., Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network Inc., Monarch HealthCare, A Medical Group Inc., Orange County Physicians IPA Medical Group Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Prospect Health Plan Inc., and United Care Medical Group, Inc. to:
    i. Extend the OneCare Connect Health Network contract through and including December 31, 2020;
    ii. Add any necessary language provisions required based on the Three-Way Cal MediConnect contract (Three-Way Agreement) between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements, including language reflecting changes related to the Merit-based Incentive Payments System (MIPS) program;
    iii. Clarify access standards for prenatal care; and
2. Physician Hospital Consortium capitated Hospital contract with Fountain Valley Regional Hospital and Medical Center, and OneCare Connect Full-Risk Health Network contracts with Heritage Provider Network Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to incorporate the retrospective non-contracted Ground Emergency Medical Transport (GEMT) provider rate increase requirements for the July 1, 2018 through June 30, 2019 and the July 1, 2019 through June 30, 2020 periods, and the additional compensation to these Health Networks for such services.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (CMC) OneCare Connect beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

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Cal MediConnect was launched in 2014 as a three-year demonstration program implemented across eight counties. OneCare Connect (OCC) was launched July 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated Health Networks to manage services to the network's assigned membership.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019. At its November 2018 meeting, the Board authorized CalOptima to extend the Health Network contracts for one year through December 31, 2019.
At its October 3, 2019 meeting, the Board authorized execution of the newest version of the three-way agreement, which became effective September 1, 2019. Among the key changes of the new agreement was extension of the Cal MediConnect demonstration period through, December 31, 2022, in one-year terms. In accordance with this change, staff is seeking authorization to extend the Health Network agreements for an additional year through December 31, 2020.

Discussion

Language Provisions; Agreement with CMS and DHCS

Contract amendments will be required to include provisions to address technical revisions and any other new/revised requirements from the new Three-Way Agreement that are applicable to the OneCare Connect Health Networks. To be in compliance with the most current version of the Three-Way Agreement received from DHCS, effective September 1, 2019, staff seeks authority to amend OneCare Connect Health Network contracts to ensure contracted OCC Health Networks ensure that providers are enrolled with DHCS as Medicaid providers consistent with all Medicaid enrollment requirements. Other changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Merit-based Incentive Payment Systems (MIPS)

In accordance with the Medicare Access and CHIP Reauthorization Act of 2015 Quality Payment Program memorandum and CalOptima Policies and Procedures, Health Networks implemented the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. This provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Payment to health networks is contingent upon annual receipt of their provider payment adjustment confirmation report, which identifies and reports all claims qualifying for MIPS payment adjustments. Health Networks are required to submit their adjustment reports on an annual basis, starting July 2020. For dates of service January 1, 2019 through December 31, 2019, payment year is 2021. Staff seeks authority to amend contracts to include language in support of the MIPS payment adjustments to the OCC Health Networks to remain in compliance with this CMS-mandated program.

Access Standards for Prenatal Care

As it relates to maternity services and access standards for prenatal care, the OneCare Connect Contract will be updated to be consistent with CalOptima's Medi-Cal Health Network contracts. The Medi-Cal Health Network contract language ensures that the most current standards or guidelines of the American

College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for prenatal services and ensure that Physician Groups have a process in place for follow-up on Member missed appointments.

Ground Emergency Medical Transport (GEMT)

Through the DHCS-established Quality Assurance Fee (QAF) program, retrospective payments to non-contracted Ground Emergency Medical Transport providers have been approved for the State Fiscal Years (SFY) 2018-2019 and 2019-2020, up to $400 per identified service. The program has been designated as a Medi-Cal benefit, requiring CalOptima to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support, Emergency), A0427 (Advanced Life Support, Level 1, Emergency), A0433 (Advanced Life Support, Level 2), A0434 (Specialty Care Transport), and A0225 (Neonatal Emergency Transport). Reimbursement of the difference between the base Medi-Cal rate for eligible services and the increase up to $400 is applicable toward the Physician Hospital Consortia capitated Hospital and Full-Risk Health Network contracts. Payments will be contingent on receipt of the GEMT payment adjustment confirmation report required from the health networks. Reimbursement payments will be made only in cases where the new Medi-Cal rate exceeds the Out-of-Network Medicare allowable reimbursement rate. These amendments will be renewed each year that GEMT provisions are extended past SFY 2019-2020.

Summary of Recommendations

Staff seeks Board authorization to amend the Health Network agreements as needed to extend and add any necessary language provisions required by the Three-Way Agreement, and to include language supporting the provision for MIPS, ACOG and GEMT.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect Health Network capitation expenses of $131 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The recommended action to renew the existing Health Network contracts through June 30, 2020, is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extensions, in the CalOptima FY 2020-21 Operating Budget.

The recommended action to amend the OneCare Connect Physician Hospital Consortium capitated hospital contract and OneCare Connect Full-Risk Health Network contracts to incorporate the retrospective non-contracted GEMT provider rate increase requirements for SFY 2018-19 is budget neutral. Funding for non-contracted GEMT provider payments for OneCare Connect was not included in the CalOptima FY 2019-20 Operating Budget approved by the Board on June 6, 2019. To date, staff has not received the most updated rates from DHCS. However, revenue from the State is anticipated to be sufficient to cover the estimated costs.

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OCC members is maintained, allows flexibility to modify OCC Health Network contracts as needed based on CalOptima's Three-Way Agreement with DHCS and CMS, support CalOptima's payment obligations under the MIPS program, ensure access standards for prenatal care are aligned with the most current ACOG standards and guidelines, and Physician Health Consortium capitated Hospital and Full-Risk Health Network contracts support GEMT payments through the end of Fiscal year 2019-2020.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated December 5, 2013; Consider Participation in the Cal MediConnect Program
3. Board Action dated September 7, 2017; Authorize and Direct Execution of a New Three-Way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program
4. Board Action dated November 1, 2018; Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts
5. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
6. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
7. CMS Release of 2019 MIPS Payment Adjustment Data File
8. Board Action dated September 5, 2019; Consider Actions Related to Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services
9. California State Plan Amendment 19-0020

/s/ Michael Schrader *10/30/2019*

Authorized Signature **Date**

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AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
ARTA Western California, Inc.	1665 Scenic Ave Dr, Suite 100	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
Talbert Medical Group, P.C.	1665 Scenic Avenue, Suite 100	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. C. Consider Participation in the Cal MediConnect Program

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400
Patti McFarland, Chief Financial Officer, (714) 246-8400

Recommended Actions
Consider the following required actions to participate in the Cal MediConnect Program:
1. Authorize and Direct the Chairman of the Board of Directors to Execute the Three-Way Agreement between the California DHCS, CMS and CalOptima for Cal MediConnect, subject to the interim final rates that will not harm the financial viability of CalOptima and reasonable and expected requirements related to operations and reporting;
2. Authorize and Direct the Chairman of the Board of Directors to Execute the California Department of Social Services' (CDSS) Contract for In-Home Supportive Services (IHSS);
3. Approve Revisions Related to Cal MediConnect to CalOptima's Fiscal Year (FY) 2013-14 Budget; and
4. Authorize the CEO to develop and/or update policies necessary to meet Cal MediConnect participation requirements and implement the program's benefit set.

Background
In June 2012, Senate Bill 1008 (2012) and SB 1036 (2012) authorized the Coordinated Care Initiative (CCI). The CCI is composed of two (2) key components that will work in tandem to improve care coordination and integration.

1. Cal MediConnect: No sooner than April 1, 2014, the state will begin a three (3) year federal-state demonstration program in eight (8) counties. Individuals with Medicare and Medi-Cal (i.e., dual eligible beneficiaries) will receive coordinated medical, behavioral health, institutional long-term care, and home and community based services through a single Medi-Cal managed care plan. The participating counties are: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside, and San Bernardino.

2. Managed Medi-Cal Long-Term Supports and Services (MLTSS): No sooner than April 1, 2014, all Medi-Cal beneficiaries, including dual eligible beneficiaries, will receive long-term services and supports and Medi-Cal wrap-around benefits through a Medi-Cal managed care plan. MLTSS includes institutional long-term care, Community Based Adult Services, Multipurpose Senior Services Program, and IHSS.

   As a County Organized Health System (COHS), CalOptima already serves dual eligible beneficiaries, and provides Medi-Cal wrap-around services to members. In addition, pursuant to SB 94 (2013), DHCS separated the MLTSS component from the Cal MediConnect program. Medi-Cal managed care plans will provide MLTSS as a Medi-Cal benefit to all enrollees even if Cal Medi-Connect does not move forward.

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DHCS initially proposed to implement Cal MediConnect no sooner than January 1, 2014. However, DHCS revised the timeline several times to accommodate ongoing negotiations with CMS and to resolve other implementation issues. On August 13, 2013, DHCS formally announced that Cal MediConnect will begin no sooner than April 1, 2014. Initial enrollment will occur on a passive enrollment basis for a twelve (12) month period, based on the eligible beneficiary's birthday month.

CalOptima's FY 2013-14 Operating Budget projected an increased enrollment of 27,000 members from the Cal MediConnect program through June 30, 2014. Staff will make a downward adjustment to the membership projection due to the delayed implementation date, and anticipates approximately 3,700 members will be passively enrolled each month. Staff will implement strategies to minimize the opt-out rate of the Cal MediConnect program.

The Demonstration Years for the Cal MediConnect program are as follows:

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

On May 3, 2012, your Board approved a pre-implementation budget for the CCI of $373,994 to proceed with the application process to participate in the program. The funds were used to support travel and training, consultant fees, limited term staffing, and outreach and engagement. The budget was for the period of May 3, 2012, through August 31, 2012.

On January 3, 2013, your Board approved additional funding to continue pre-implementation planning for the CCI of $615,000 for a total of $988,994. The funds were used to support professional fees and staffing. To date, approximately ninety-five percent (95%) of the pre-implementation funds have been spent. Based on Board approval, staff has completed all state and federal applications and additional requests, including but not limited to:

Key Deliverables	Date
DHCS Request for Solutions	February 23, 2012
CMS Capitated Financial Alignment Demonstration application	May 23, 2012
Proposed Model of Care	June 29, 2012
Proposed Medication Management Therapy Program	May 6, 2013
Proposed Part D Formulary	May 31, 2013
Proposed Plan Benefit Package	June 3, 2013
Revised Health Service Delivery Tables for Network Validation	June 26, 2013

Key steps and milestones for the Cal MediConnect program are as follows:

Key Steps and Milestones	Date
Finalize Memorandum of Understanding (MOU) (CMS and DHCS)	Executed March 27, 2013

Key Steps and Milestones	Date
Develop final capitation rates	Ongoing since April 23, 2013
Conduct joint readiness assessments (CMS and DHCS)	Initiated March 2013 and ongoing through December 2013 - Desk Review: April 19, 2013 - On-site visit: July 25-26, 2013 - Remote Systems Testing: October 21, 2013 - Network Validation: October 28, 2013 - Pre-Enrollment Validation: November 20, 2013 - Final Readiness report to be issued mid-December 2013
Execute MOUs with relevant county agencies	Completed in July and August 2013
Sign Three-Way contract	December 13, 2013 (electronic signature) December 16, 2013 (hard copy signature)
Sign CDSS contract for IHSS services	Mid-December 2013 (anticipated)
Finalize Plan Benefit Package in CMS system	Mid-December 2013
Implement Cal MediConnect	No sooner than April 1, 2014

On June 6, 2013, your Board approved CalOptima's FY 2013-14 Operating Budget. Staff clarified that the operating budget did not include infrastructure and implementation funding for the Duals Demonstration (i.e., the Cal MediConnect program), and that Staff would present the budget as a separate Board action.

Discussion

Both DHCS and CMS are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of Cal MediConnect. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted, as noted above, from the prior dates shared with the Board in previous meetings. Staff participated in the on-site readiness review July 25-26, 2013.

The next key step is for CalOptima to sign the Three-Way Agreement with CMS and DHCS. Recently, DHCS notified participating plans that the final date by which CMS will require execution of the Agreement is December 10, 2013. Plans, including CalOptima, received the "final" Three-Way Agreement on November 6, 2013 and were advised that they would not be able to negotiate changes to the Agreement. Although the document contains a number of terms that are currently in other program agreements, this was the first time that plans received the document which contains new Cal MediConnect program requirements, Plans had approximately one week to review the document and submit a list of "significant concerns" to the Agreement. DHCS held a conference call with plans on November 20, 2013 to discuss the comments plans submitted. On the call, the DHCS provided clarification on certain terms, but essentially reiterated that the "final" version was, in fact, final. CMS and DHCS issued interim final rates in late October for plans' thirty (30) day review. Additionally, DHCS has indicated that rates may be subject to additional minor revisions prior to the final execution of the Agreement.

Three-Way Cal MediConnect Agreement

The Agreement between DHCS, CMS, and CalOptima outlines the respective obligations for each party to implement the Cal MediConnect program in Orange County. The Agreement contains provisions for CMS

and DHCS to evaluate CalOptima's performance as a Cal MediConnect participating plan, including adherence to federal Medicare and Medicaid laws.

Below are some areas within the Agreement that will have a significant operational and financial impact:

Requirement / Area of Concern	Impact
Benefits and funding streams	The Agreement reflects continued fragmentation of Medicare and Medi-Cal benefits, services, and funding streams will pose operational challenges. Full integration will likely not occur until year 2 of the demonstration.
Care coordination	The Agreement includes extensive care coordination requirements that conflict with the existing Medicare requirements for a plan's Model of Care are included in the Agreement. Specifically, the ten (10) day timeframe to develop Individualized Care Plans (ICPs) for members after completion of the Health Risk Assessment (HRA) is insufficient.
Rate dispute process	The Agreement excludes rates from the dispute process. Requiring participating plans to waive their legal rights to dispute a rate that may be unreasonable or actuarially unsound is particularly problematic in year 2 and 3 of the demonstration.
Quality withholds	There is a lack of specific information on the quality withhold metrics, and how plans will be measured for purposes of earning back the withheld amount based on performance. The agreement lacks a process for plans to provide meaningful input on the performance metrics that will be tied to the quality withholds for each Demonstration year.
IHSS	Plans are required to assume full risk for IHSS provider payments (i.e., wages and benefits, such as health insurance). The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December. CalOptima Board of Directors would likely have to make a "go / no-go" decision on the 3-way contract for Cal MediConnect in December without the opportunity to review the CDSS contract.
After-hours call capacity	Plans cannot leverage current 24-hour Nurse Advice Lines to meet the after-hours call capacity requirement as the after-hours call service needs to be staffed either by a physician or an appropriate licensed professional under his or her supervision.

Requirement / Area of Concern	Impact
Pending contracts and regulatory guidance	The Agreement incorporates requirements to comply with unissued CMS/DHCS guidance. These references in the Agreement are broad and are not limited to indicating that the guidance will do no more than interpret current requirements under State and Federal laws.
Advisory Committee	Requires the formation of a new Advisory Committee to the Board of Directors, which must consist of not more than eleven (11) people, and no less than fifty percent (50%) of the membership of the advisory committee shall be individuals who are users of personal assistance paid for through public or private funds or recipients of IHSS services.

Other issues related to the Three-Way Agreement for Cal MediConnect include:

- Lack of specific information on IHSS;
  - Data sharing issues with the California Department of Social Services (CDSS) for IHSS; and
  - Contract terms for agreement with CDSS. The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December.

- Reporting requirements not yet specified (e.g., network adequacy, performance measures).

Revisions to CalOptima's FY 2013-14 Implementation, Operating, and Capital Budgets
Staff is submitting revisions to the FY 2013-14 Implementation, Operating, and Capital Budget to the BOD for approval with assumptions based on currently available information.

Proposed Budget 1/1/14 – 6/30/14			
	Implementation	**Operational**	**Total**
Average Monthly Enrollment	N/A	7,118	7,118
Revenue	$0	$43,130,331	$43,130,331
Medical Costs	$2,845,316	$38,414,385	$41,259,701
Administrative Costs	$2,879,267	$4,069,166	$6,948,433
Operating Income/(Loss)	($5,724,583)	$646,780	($5,077,803)
Medical Loss Ratio (MLR)	N/A	89.1%	95.7%
Administrative Loss Ratio (ALR)	N/A	9.4%	16.1%
Capital – Hardware/Software			$1,100,000

Enrollment Assumptions:
- Begins April 1, 2014 with an estimated 3,680 members
- Assumes a pre-enrollment opt-out rate of 20% and disenrollment rate of 5%

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- CY 2014 enrollment will consist of FFS Medicare membership, since Medicare Advantage enrollees are allowed to stay with existing plan through Dec 2014

Revenue Assumptions:
- Bases Medicare rates on draft rates provided in October 2013
- Bases Medi-Cal rates on draft rates provided on November 20, 2013
- Estimates total revenue of $2,019.74 per member per month
- Medicare Part A/B and Part D rates utilizes a base rate and applies a risk adjustment factor (similar to OneCare revenue)
- Medi-Cal rate is a blended rate of four population cohorts: LTC, HCBS High, HCBS Low, and Community Well
- Adjusts rates for savings targets that escalate from 1.4% to 5.5% over the next three and a half years

Medical Cost Assumptions:
- Assumes an average provider capitation rate of 37.5% of Medicare Part A/B premium
- Uses current OneCare medical utilization and unit cost rates as a proxy
- Assumes an MLR of 85.3% on prescription drug benefits
- Assumes an MLR of 90.3% on Medi-Cal wrap-around benefits
- Excludes supplemental benefits with the exception of mental health and transportation services
- Includes program guidelines that require higher levels of Case Management and Health Services
- Estimates eighty-two (82) FTE's are scheduled over the remainder of the year

Administrative Cost Assumptions:
- Includes implementation costs of $5.7 million to prepare the organizations processes, policies, and staff for a targeted go-live date of April 1, 2014
- Program guidelines specify staffing requirements, such as Compliance and Customer Service
- Estimates sixty-three (63) FTE's are scheduled over the remainder of the year
- First twelve (12) months of the program will require higher than standard level of cost for initial items such as member and provider mailings as well as staff recruitment and training. These costs are staged in to occur approximately three (3) months prior to the member enrollment.

Capital Assumptions:
- Includes hardware and software required to support the increase in staffing and projected membership population

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
CCMS (Medical Database)	$ 222,300	20%
Facets Upgrades	204,300	19%
Backup Environment	67,240	6%
Core Infrastructure	58,020	5%
Data Warehouse	43,000	4%

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Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
Misc (Network Costs)	505,140	46%
Total	$ 1,100,000	100%

The Proposed budget includes hardware, software, and professional fees.

Next Steps:
After receipt and review of the Three-Way Agreement and analysis of the interim final rates, Staff recommends the BOD to authorize the Chairman to execute the Three-Way Agreement for CalOptima to participate in Cal MediConnect.

Concurrently, Staff will continue to prepare for the implementation of Cal MediConnect and Managed MLTSS.

Approval of the proposed actions and the Board Chair's execution of the three-way agreement with CMS and DHCS will commit CalOptima to participating in the Cal MediConnect Program.

Fiscal Impact
As outlined above, the proposed revisions to the CalOptima FY 2013-14 Implementation and Operating Budget reflect a deficit of $5.1 million and a Capital Budget of $1.1 million.

Rationale for Recommendation
The DHCS proposal to implement the CCI aligns with CalOptima's long standing commitment to better integrate acute and long term care services. This integration initiative provides CalOptima an opportunity to work with community stakeholders to design a system that fully integrates the administrative and financial responsibilities for Medi-Cal and Medicare covered services and achieve its acute and long term care integration goals.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *11/27/2013*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

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policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

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Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

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Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

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APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

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Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

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- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: January 8, 2019

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer R. Shapiro, Acting Director, Medicare Plan Payment Group

SUBJECT: **Release of 2019 MIPS Payment Adjustment Data File**

The Centers for Medicare & Medicaid Services (CMS) has uploaded to the Health Plan Management System (HPMS) the Merit-based Incentive Payment System (MIPS) Payment Adjustment Data File for payment year 2019. Medicare Advantage organizations (MAOs) can use the information in the file to determine the amount of the MIPS payment adjustment that applies to their payments for Medicare Part B covered professional services furnished by out-of-network MIPS eligible clinicians.

For guidance on when and how the MIPS payments apply to MAOs' payments to MIPS eligible clinicians, please see the April 27, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments" and the November 8, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance."

File Access

The 2019 MIPS Payment Adjustment Data File has been added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). After navigating to the "Incentive Payments" section, a user may download the file by selecting "MIPS Payment Adjustment Data File" under Step One, "2019" under Step Two, and "Download" under Step Three.

Due to the sensitivity of some of the information provided in the file, only the MAO's Medicare Compliance Officer will be able to access and download it. The Compliance Officer must be a registered HPMS user in order to obtain the file.

Identifying the Applicable MIPS Adjustment Percentage

The MIPS Payment Adjustment Data File consists of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)

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- MIPS adjustment percentage
- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see the attached Appendix.

An MAO can identify the applicable MIPS adjustment percentage for a MIPS eligible clinician by matching the clinician's billing TIN/NPI combination to a TIN/NPI combination in the MIPS Payment Adjustment Data File. If an exact match for the billing TIN/NPI combination does not appear in the data file, the MAO should determine whether the NPI appears in combination with another TIN and, if so, apply the MIPS adjustment percentage associated with that TIN/NPI combination. If the NPI appears in more than one TIN/NPI combination in the data file, the MAO should apply the MIPS adjustment percentage for the TIN/NPI combination that results in the greatest total payment amount.

Additional Information

If you encounter technical difficulties when downloading the MIPS Payment Adjustment Data File from HPMS, you may contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028.

If the "Incentive Payments" hyperlink does not appear in the HPMS Data Extract Facility, you must send a request for additional access to hpms_access@cms.hhs.gov. Please note that information in the MIPS Payment Adjustment Data File is considered sensitive and may require additional levels of approval.

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

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increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

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Attachment to the September 5, 2019 Board of Directors Meeting – Agenda Item 9

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Regional Operations Group

September 6, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 19-0020, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 30, 2019. SPA 19-0020 continues the Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers to Medi-Cal patients from July 1, 2019 to June 30, 2020.

The effective date of this SPA is July 1, 2019. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard C. Allen
Director
Western Regional Operations Group

cc: Jacey Cooper, California Department of Health Care Services (DHCS)
Lindy Harrington, DHCS
Connie Florez, DHCS
Michelle Tamai, DHCS
Adam Neighbours, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 19 — 00 20

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: Title 42 CFR 447 Subpart F

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ 2019 $ $4,809,054
b. FFY ~~2019~~ 2020 $ $14,427,163

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 29, Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Supplement 29, Attachment 4.19-B, pages 1-2

10. SUBJECT OF AMENDMENT

One-year reimbursement rate add-on for ground emergency medical transports with dates of service between July 1, 2019 and June 30, 2020.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME: Mari Cantwell

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: July 30, 2019

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: July 30, 2019

18. DATE APPROVED: September 6, 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME: Richard C. Allen

22. TITLE: Director, Center for Medicaid & CHIP Services, Regional Operations Group

23. REMARKS

For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.

Box 7: CMS pen and ink change to update years per state response to informal questions dated 8/21/19.

FORM CMS-179 (07/92)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, as described below, effective July 1, 2018 through June 30, 2019 and July 1, 2019 through June 30, 2020. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429 BLS Emergency, A0427 ALS Emergency, A0433 ALS2, A0434 Specialty Care Transport, and A0225 Neonatal Emergency Transport. An "emergency medical transport" does not occur when, following evaluation of a patient, a transport is not provided.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for SFY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 is $339.00. The add-on is paid on a per-claim basis.

For SFY 2019-20, the reimbursement rate add-on is fixed. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, A0433, and A0434 is $339.00, and for CPT Code A0225 is $400.72. The add-on is paid for each eligible CPT Code on a per-claim basis.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

Service Code	Description	Current Payment*	Add On Amount	Resulting Total Payment
A0429	Basic Life Support, Emergency	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00
A0434	Specialty Care Transport	$118.20	$220.80	$339.00
A0225	Neonatal Emergency Transport	$179.92	$220.80	$400.72

*These are the base rates associated with these codes, but are subject to further adjustments pursuant to the State Plan.

The resulting total payment amount as listed in the table above for the applicable CPT Code is considered the Rogers rate, which managed care organizations shall pay noncontract managed care emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code, for each state fiscal year the FFS reimbursement rate add-on is effective.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, except those associated with AltaMed Health Services Corporation, to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

Contact

Michelle Laughlin, Executive Director, Network Operations (714) 246-8400
Nancy Huang, Interim Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the OneCare Connect:

1. Health Network contracts with AMVI Care Health Network, ARTA Western California, Inc., Talbert Medical Group, P.C., Family Choice Medical Group Inc., Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network Inc., Monarch HealthCare, A Medical Group Inc., Orange County Physicians IPA Medical Group Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Prospect Health Plan Inc., and United Care Medical Group, Inc. to:
    i. Extend the OneCare Connect Health Network contract through and including December 31, 2020;
    ii. Add any necessary language provisions required based on the Three-Way Cal MediConnect contract (Three-Way Agreement) between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements, including language reflecting changes related to the Merit-based Incentive Payments System (MIPS) program;
    iii. Clarify access standards for prenatal care; and
2. Physician Hospital Consortium capitated Hospital contract with Fountain Valley Regional Hospital and Medical Center, and OneCare Connect Full-Risk Health Network contracts with Heritage Provider Network Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to incorporate the retrospective non-contracted Ground Emergency Medical Transport (GEMT) provider rate increase requirements for the July 1, 2018 through June 30, 2019 and the July 1, 2019 through June 30, 2020 periods, and the additional compensation to these Health Networks for such services.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (CMC) OneCare Connect beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

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Cal MediConnect was launched in 2014 as a three-year demonstration program implemented across eight counties. OneCare Connect (OCC) was launched July 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated Health Networks to manage services to the network's assigned membership.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019. At its November 2018 meeting, the Board authorized CalOptima to extend the Health Network contracts for one year through December 31, 2019.
At its October 3, 2019 meeting, the Board authorized execution of the newest version of the three-way agreement, which became effective September 1, 2019. Among the key changes of the new agreement was extension of the Cal MediConnect demonstration period through, December 31, 2022, in one-year terms. In accordance with this change, staff is seeking authorization to extend the Health Network agreements for an additional year through December 31, 2020.

Discussion

Language Provisions; Agreement with CMS and DHCS

Contract amendments will be required to include provisions to address technical revisions and any other new/revised requirements from the new Three-Way Agreement that are applicable to the OneCare Connect Health Networks. To be in compliance with the most current version of the Three-Way Agreement received from DHCS, effective September 1, 2019, staff seeks authority to amend OneCare Connect Health Network contracts to ensure contracted OCC Health Networks ensure that providers are enrolled with DHCS as Medicaid providers consistent with all Medicaid enrollment requirements. Other changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Merit-based Incentive Payment Systems (MIPS)

In accordance with the Medicare Access and CHIP Reauthorization Act of 2015 Quality Payment Program memorandum and CalOptima Policies and Procedures, Health Networks implemented the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. This provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Payment to health networks is contingent upon annual receipt of their provider payment adjustment confirmation report, which identifies and reports all claims qualifying for MIPS payment adjustments. Health Networks are required to submit their adjustment reports on an annual basis, starting July 2020. For dates of service January 1, 2019 through December 31, 2019, payment year is 2021. Staff seeks authority to amend contracts to include language in support of the MIPS payment adjustments to the OCC Health Networks to remain in compliance with this CMS-mandated program.

Access Standards for Prenatal Care

As it relates to maternity services and access standards for prenatal care, the OneCare Connect Contract will be updated to be consistent with CalOptima's Medi-Cal Health Network contracts. The Medi-Cal Health Network contract language ensures that the most current standards or guidelines of the American

College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for prenatal services and ensure that Physician Groups have a process in place for follow-up on Member missed appointments.

Ground Emergency Medical Transport (GEMT)

Through the DHCS-established Quality Assurance Fee (QAF) program, retrospective payments to non-contracted Ground Emergency Medical Transport providers have been approved for the State Fiscal Years (SFY) 2018-2019 and 2019-2020, up to $400 per identified service. The program has been designated as a Medi-Cal benefit, requiring CalOptima to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support, Emergency), A0427 (Advanced Life Support, Level 1, Emergency), A0433 (Advanced Life Support, Level 2), A0434 (Specialty Care Transport), and A0225 (Neonatal Emergency Transport). Reimbursement of the difference between the base Medi-Cal rate for eligible services and the increase up to $400 is applicable toward the Physician Hospital Consortia capitated Hospital and Full-Risk Health Network contracts. Payments will be contingent on receipt of the GEMT payment adjustment confirmation report required from the health networks. Reimbursement payments will be made only in cases where the new Medi-Cal rate exceeds the Out-of-Network Medicare allowable reimbursement rate. These amendments will be renewed each year that GEMT provisions are extended past SFY 2019-2020.

Summary of Recommendations

Staff seeks Board authorization to amend the Health Network agreements as needed to extend and add any necessary language provisions required by the Three-Way Agreement, and to include language supporting the provision for MIPS, ACOG and GEMT.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect Health Network capitation expenses of $131 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The recommended action to renew the existing Health Network contracts through June 30, 2020, is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extensions, in the CalOptima FY 2020-21 Operating Budget.

The recommended action to amend the OneCare Connect Physician Hospital Consortium capitated hospital contract and OneCare Connect Full-Risk Health Network contracts to incorporate the retrospective non-contracted GEMT provider rate increase requirements for SFY 2018-19 is budget neutral. Funding for non-contracted GEMT provider payments for OneCare Connect was not included in the CalOptima FY 2019-20 Operating Budget approved by the Board on June 6, 2019. To date, staff has not received the most updated rates from DHCS. However, revenue from the State is anticipated to be sufficient to cover the estimated costs.

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OCC members is maintained, allows flexibility to modify OCC Health Network contracts as needed based on CalOptima's Three-Way Agreement with DHCS and CMS, support CalOptima's payment obligations under the MIPS program, ensure access standards for prenatal care are aligned with the most current ACOG standards and guidelines, and Physician Health Consortium capitated Hospital and Full-Risk Health Network contracts support GEMT payments through the end of Fiscal year 2019-2020.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated December 5, 2013; Consider Participation in the Cal MediConnect Program
3. Board Action dated September 7, 2017; Authorize and Direct Execution of a New Three-Way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program
4. Board Action dated November 1, 2018; Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts
5. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
6. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
7. CMS Release of 2019 MIPS Payment Adjustment Data File
8. Board Action dated September 5, 2019; Consider Actions Related to Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services
9. California State Plan Amendment 19-0020

/s/ Michael Schrader *10/30/2019*

Authorized Signature **Date**

AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
ARTA Western California, Inc.	1665 Scenic Ave Dr, Suite 100	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
Talbert Medical Group, P.C.	1665 Scenic Avenue, Suite 100	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. C. Consider Participation in the Cal MediConnect Program

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400
Patti McFarland, Chief Financial Officer, (714) 246-8400

Recommended Actions
Consider the following required actions to participate in the Cal MediConnect Program:
1. Authorize and Direct the Chairman of the Board of Directors to Execute the Three-Way Agreement between the California DHCS, CMS and CalOptima for Cal MediConnect, subject to the interim final rates that will not harm the financial viability of CalOptima and reasonable and expected requirements related to operations and reporting;
2. Authorize and Direct the Chairman of the Board of Directors to Execute the California Department of Social Services' (CDSS) Contract for In-Home Supportive Services (IHSS);
3. Approve Revisions Related to Cal MediConnect to CalOptima's Fiscal Year (FY) 2013-14 Budget; and
4. Authorize the CEO to develop and/or update policies necessary to meet Cal MediConnect participation requirements and implement the program's benefit set.

Background
In June 2012, Senate Bill 1008 (2012) and SB 1036 (2012) authorized the Coordinated Care Initiative (CCI). The CCI is composed of two (2) key components that will work in tandem to improve care coordination and integration.

1. Cal MediConnect: No sooner than April 1, 2014, the state will begin a three (3) year federal-state demonstration program in eight (8) counties. Individuals with Medicare and Medi-Cal (i.e., dual eligible beneficiaries) will receive coordinated medical, behavioral health, institutional long-term care, and home and community based services through a single Medi-Cal managed care plan. The participating counties are: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside, and San Bernardino.

2. Managed Medi-Cal Long-Term Supports and Services (MLTSS): No sooner than April 1, 2014, all Medi-Cal beneficiaries, including dual eligible beneficiaries, will receive long-term services and supports and Medi-Cal wrap-around benefits through a Medi-Cal managed care plan. MLTSS includes institutional long-term care, Community Based Adult Services, Multipurpose Senior Services Program, and IHSS.

   As a County Organized Health System (COHS), CalOptima already serves dual eligible beneficiaries, and provides Medi-Cal wrap-around services to members. In addition, pursuant to SB 94 (2013), DHCS separated the MLTSS component from the Cal MediConnect program. Medi-Cal managed care plans will provide MLTSS as a Medi-Cal benefit to all enrollees even if Cal Medi-Connect does not move forward.

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DHCS initially proposed to implement Cal MediConnect no sooner than January 1, 2014. However, DHCS revised the timeline several times to accommodate ongoing negotiations with CMS and to resolve other implementation issues. On August 13, 2013, DHCS formally announced that Cal MediConnect will begin no sooner than April 1, 2014. Initial enrollment will occur on a passive enrollment basis for a twelve (12) month period, based on the eligible beneficiary's birthday month.

CalOptima's FY 2013-14 Operating Budget projected an increased enrollment of 27,000 members from the Cal MediConnect program through June 30, 2014. Staff will make a downward adjustment to the membership projection due to the delayed implementation date, and anticipates approximately 3,700 members will be passively enrolled each month. Staff will implement strategies to minimize the opt-out rate of the Cal MediConnect program.

The Demonstration Years for the Cal MediConnect program are as follows:

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

On May 3, 2012, your Board approved a pre-implementation budget for the CCI of $373,994 to proceed with the application process to participate in the program. The funds were used to support travel and training, consultant fees, limited term staffing, and outreach and engagement. The budget was for the period of May 3, 2012, through August 31, 2012.

On January 3, 2013, your Board approved additional funding to continue pre-implementation planning for the CCI of $615,000 for a total of $988,994. The funds were used to support professional fees and staffing. To date, approximately ninety-five percent (95%) of the pre-implementation funds have been spent. Based on Board approval, staff has completed all state and federal applications and additional requests, including but not limited to:

Key Deliverables	Date
DHCS Request for Solutions	February 23, 2012
CMS Capitated Financial Alignment Demonstration application	May 23, 2012
Proposed Model of Care	June 29, 2012
Proposed Medication Management Therapy Program	May 6, 2013
Proposed Part D Formulary	May 31, 2013
Proposed Plan Benefit Package	June 3, 2013
Revised Health Service Delivery Tables for Network Validation	June 26, 2013

Key steps and milestones for the Cal MediConnect program are as follows:

Key Steps and Milestones	Date
Finalize Memorandum of Understanding (MOU) (CMS and DHCS)	Executed March 27, 2013

Key Steps and Milestones	Date
Develop final capitation rates	Ongoing since April 23, 2013
Conduct joint readiness assessments (CMS and DHCS)	Initiated March 2013 and ongoing through December 2013 - Desk Review: April 19, 2013 - On-site visit: July 25-26, 2013 - Remote Systems Testing: October 21, 2013 - Network Validation: October 28, 2013 - Pre-Enrollment Validation: November 20, 2013 - Final Readiness report to be issued mid-December 2013
Execute MOUs with relevant county agencies	Completed in July and August 2013
Sign Three-Way contract	December 13, 2013 (electronic signature) December 16, 2013 (hard copy signature)
Sign CDSS contract for IHSS services	Mid-December 2013 (anticipated)
Finalize Plan Benefit Package in CMS system	Mid-December 2013
Implement Cal MediConnect	No sooner than April 1, 2014

On June 6, 2013, your Board approved CalOptima's FY 2013-14 Operating Budget. Staff clarified that the operating budget did not include infrastructure and implementation funding for the Duals Demonstration (i.e., the Cal MediConnect program), and that Staff would present the budget as a separate Board action.

Discussion

Both DHCS and CMS are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of Cal MediConnect. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted, as noted above, from the prior dates shared with the Board in previous meetings. Staff participated in the on-site readiness review July 25-26, 2013.

The next key step is for CalOptima to sign the Three-Way Agreement with CMS and DHCS. Recently, DHCS notified participating plans that the final date by which CMS will require execution of the Agreement is December 10, 2013. Plans, including CalOptima, received the "final" Three-Way Agreement on November 6, 2013 and were advised that they would not be able to negotiate changes to the Agreement. Although the document contains a number of terms that are currently in other program agreements, this was the first time that plans received the document which contains new Cal MediConnect program requirements, Plans had approximately one week to review the document and submit a list of "significant concerns" to the Agreement. DHCS held a conference call with plans on November 20, 2013 to discuss the comments plans submitted. On the call, the DHCS provided clarification on certain terms, but essentially reiterated that the "final" version was, in fact, final. CMS and DHCS issued interim final rates in late October for plans' thirty (30) day review. Additionally, DHCS has indicated that rates may be subject to additional minor revisions prior to the final execution of the Agreement.

Three-Way Cal MediConnect Agreement

The Agreement between DHCS, CMS, and CalOptima outlines the respective obligations for each party to implement the Cal MediConnect program in Orange County. The Agreement contains provisions for CMS

and DHCS to evaluate CalOptima's performance as a Cal MediConnect participating plan, including adherence to federal Medicare and Medicaid laws.

Below are some areas within the Agreement that will have a significant operational and financial impact:

Requirement / Area of Concern	Impact
Benefits and funding streams	The Agreement reflects continued fragmentation of Medicare and Medi-Cal benefits, services, and funding streams will pose operational challenges. Full integration will likely not occur until year 2 of the demonstration.
Care coordination	The Agreement includes extensive care coordination requirements that conflict with the existing Medicare requirements for a plan's Model of Care are included in the Agreement. Specifically, the ten (10) day timeframe to develop Individualized Care Plans (ICPs) for members after completion of the Health Risk Assessment (HRA) is insufficient.
Rate dispute process	The Agreement excludes rates from the dispute process. Requiring participating plans to waive their legal rights to dispute a rate that may be unreasonable or actuarially unsound is particularly problematic in year 2 and 3 of the demonstration.
Quality withholds	There is a lack of specific information on the quality withhold metrics, and how plans will be measured for purposes of earning back the withheld amount based on performance. The agreement lacks a process for plans to provide meaningful input on the performance metrics that will be tied to the quality withholds for each Demonstration year.
IHSS	Plans are required to assume full risk for IHSS provider payments (i.e., wages and benefits, such as health insurance). The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December. CalOptima Board of Directors would likely have to make a "go / no-go" decision on the 3-way contract for Cal MediConnect in December without the opportunity to review the CDSS contract.
After-hours call capacity	Plans cannot leverage current 24-hour Nurse Advice Lines to meet the after-hours call capacity requirement as the after-hours call service needs to be staffed either by a physician or an appropriate licensed professional under his or her supervision.

Requirement / Area of Concern	Impact
Pending contracts and regulatory guidance	The Agreement incorporates requirements to comply with unissued CMS/DHCS guidance. These references in the Agreement are broad and are not limited to indicating that the guidance will do no more than interpret current requirements under State and Federal laws.
Advisory Committee	Requires the formation of a new Advisory Committee to the Board of Directors, which must consist of not more than eleven (11) people, and no less than fifty percent (50%) of the membership of the advisory committee shall be individuals who are users of personal assistance paid for through public or private funds or recipients of IHSS services.

Other issues related to the Three-Way Agreement for Cal MediConnect include:

- Lack of specific information on IHSS;
  - Data sharing issues with the California Department of Social Services (CDSS) for IHSS; and
  - Contract terms for agreement with CDSS. The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December.

- Reporting requirements not yet specified (e.g., network adequacy, performance measures).

Revisions to CalOptima's FY 2013-14 Implementation, Operating, and Capital Budgets
Staff is submitting revisions to the FY 2013-14 Implementation, Operating, and Capital Budget to the BOD for approval with assumptions based on currently available information.

Proposed Budget 1/1/14 – 6/30/14			
	Implementation	**Operational**	**Total**
Average Monthly Enrollment	N/A	7,118	7,118
Revenue	$0	$43,130,331	$43,130,331
Medical Costs	$2,845,316	$38,414,385	$41,259,701
Administrative Costs	$2,879,267	$4,069,166	$6,948,433
Operating Income/(Loss)	($5,724,583)	$646,780	($5,077,803)
Medical Loss Ratio (MLR)	N/A	89.1%	95.7%
Administrative Loss Ratio (ALR)	N/A	9.4%	16.1%
Capital – Hardware/Software			$1,100,000

Enrollment Assumptions:
- Begins April 1, 2014 with an estimated 3,680 members
- Assumes a pre-enrollment opt-out rate of 20% and disenrollment rate of 5%

- CY 2014 enrollment will consist of FFS Medicare membership, since Medicare Advantage enrollees are allowed to stay with existing plan through Dec 2014

Revenue Assumptions:
- Bases Medicare rates on draft rates provided in October 2013
- Bases Medi-Cal rates on draft rates provided on November 20, 2013
- Estimates total revenue of $2,019.74 per member per month
- Medicare Part A/B and Part D rates utilizes a base rate and applies a risk adjustment factor (similar to OneCare revenue)
- Medi-Cal rate is a blended rate of four population cohorts: LTC, HCBS High, HCBS Low, and Community Well
- Adjusts rates for savings targets that escalate from 1.4% to 5.5% over the next three and a half years

Medical Cost Assumptions:
- Assumes an average provider capitation rate of 37.5% of Medicare Part A/B premium
- Uses current OneCare medical utilization and unit cost rates as a proxy
- Assumes an MLR of 85.3% on prescription drug benefits
- Assumes an MLR of 90.3% on Medi-Cal wrap-around benefits
- Excludes supplemental benefits with the exception of mental health and transportation services
- Includes program guidelines that require higher levels of Case Management and Health Services
- Estimates eighty-two (82) FTE's are scheduled over the remainder of the year

Administrative Cost Assumptions:
- Includes implementation costs of $5.7 million to prepare the organizations processes, policies, and staff for a targeted go-live date of April 1, 2014
- Program guidelines specify staffing requirements, such as Compliance and Customer Service
- Estimates sixty-three (63) FTE's are scheduled over the remainder of the year
- First twelve (12) months of the program will require higher than standard level of cost for initial items such as member and provider mailings as well as staff recruitment and training. These costs are staged in to occur approximately three (3) months prior to the member enrollment.

Capital Assumptions:
- Includes hardware and software required to support the increase in staffing and projected membership population

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
CCMS (Medical Database)	$ 222,300	20%
Facets Upgrades	204,300	19%
Backup Environment	67,240	6%
Core Infrastructure	58,020	5%
Data Warehouse	43,000	4%

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
Misc (Network Costs)	505,140	46%
Total	$ 1,100,000	100%

The Proposed budget includes hardware, software, and professional fees.

Next Steps:
After receipt and review of the Three-Way Agreement and analysis of the interim final rates, Staff recommends the BOD to authorize the Chairman to execute the Three-Way Agreement for CalOptima to participate in Cal MediConnect.

Concurrently, Staff will continue to prepare for the implementation of Cal MediConnect and Managed MLTSS.

Approval of the proposed actions and the Board Chair's execution of the three-way agreement with CMS and DHCS will commit CalOptima to participating in the Cal MediConnect Program.

Fiscal Impact
As outlined above, the proposed revisions to the CalOptima FY 2013-14 Implementation and Operating Budget reflect a deficit of $5.1 million and a Capital Budget of $1.1 million.

Rationale for Recommendation
The DHCS proposal to implement the CCI aligns with CalOptima's long standing commitment to better integrate acute and long term care services. This integration initiative provides CalOptima an opportunity to work with community stakeholders to design a system that fully integrates the administrative and financial responsibilities for Medi-Cal and Medicare covered services and achieve its acute and long term care integration goals.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/27/2013*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

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- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: January 8, 2019

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer R. Shapiro, Acting Director, Medicare Plan Payment Group

SUBJECT: **Release of 2019 MIPS Payment Adjustment Data File**

The Centers for Medicare & Medicaid Services (CMS) has uploaded to the Health Plan Management System (HPMS) the Merit-based Incentive Payment System (MIPS) Payment Adjustment Data File for payment year 2019. Medicare Advantage organizations (MAOs) can use the information in the file to determine the amount of the MIPS payment adjustment that applies to their payments for Medicare Part B covered professional services furnished by out-of-network MIPS eligible clinicians.

For guidance on when and how the MIPS payments apply to MAOs' payments to MIPS eligible clinicians, please see the April 27, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments" and the November 8, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance."

File Access

The 2019 MIPS Payment Adjustment Data File has been added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). After navigating to the "Incentive Payments" section, a user may download the file by selecting "MIPS Payment Adjustment Data File" under Step One, "2019" under Step Two, and "Download" under Step Three.

Due to the sensitivity of some of the information provided in the file, only the MAO's Medicare Compliance Officer will be able to access and download it. The Compliance Officer must be a registered HPMS user in order to obtain the file.

Identifying the Applicable MIPS Adjustment Percentage

The MIPS Payment Adjustment Data File consists of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)

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- MIPS adjustment percentage
- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see the attached Appendix.

An MAO can identify the applicable MIPS adjustment percentage for a MIPS eligible clinician by matching the clinician's billing TIN/NPI combination to a TIN/NPI combination in the MIPS Payment Adjustment Data File. If an exact match for the billing TIN/NPI combination does not appear in the data file, the MAO should determine whether the NPI appears in combination with another TIN and, if so, apply the MIPS adjustment percentage associated with that TIN/NPI combination. If the NPI appears in more than one TIN/NPI combination in the data file, the MAO should apply the MIPS adjustment percentage for the TIN/NPI combination that results in the greatest total payment amount.

Additional Information

If you encounter technical difficulties when downloading the MIPS Payment Adjustment Data File from HPMS, you may contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028.

If the "Incentive Payments" hyperlink does not appear in the HPMS Data Extract Facility, you must send a request for additional access to hpms_access@cms.hhs.gov. Please note that information in the MIPS Payment Adjustment Data File is considered sensitive and may require additional levels of approval.

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

Appendix

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

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increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

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Attachment to the September 5, 2019 Board of Directors Meeting – Agenda Item 9

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Regional Operations Group

September 6, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 19-0020, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 30, 2019. SPA 19-0020 continues the Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers to Medi-Cal patients from July 1, 2019 to June 30, 2020.

The effective date of this SPA is July 1, 2019. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard C. Allen
Director
Western Regional Operations Group

cc: Jacey Cooper, California Department of Health Care Services (DHCS)
Lindy Harrington, DHCS
Connie Florez, DHCS
Michelle Tamai, DHCS
Adam Neighbours, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 19 — 00 20

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: Title 42 CFR 447 Subpart F

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ 2019 $ $4,809,054
b. FFY ~~2019~~ 2020 $ $14,427,163

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 29, Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Supplement 29, Attachment 4.19-B, pages 1-2

10. SUBJECT OF AMENDMENT

One-year reimbursement rate add-on for ground emergency medical transports with dates of service between July 1, 2019 and June 30, 2020.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Mari Cantwell

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: July 30, 2019

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: July 30, 2019

18. DATE APPROVED: September 6, 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Richard C. Allen

22. TITLE: Director, Center for Medicaid & CHIP Services, Regional Operations Group

23. REMARKS

For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.

Box 7: CMS pen and ink change to update years per state response to informal questions dated 8/21/19.

FORM CMS-179 (07/92)

Instructions on Back

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, as described below, effective July 1, 2018 through June 30, 2019 and July 1, 2019 through June 30, 2020. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429 BLS Emergency, A0427 ALS Emergency, A0433 ALS2, A0434 Specialty Care Transport, and A0225 Neonatal Emergency Transport. An "emergency medical transport" does not occur when, following evaluation of a patient, a transport is not provided.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for SFY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 is $339.00. The add-on is paid on a per-claim basis.

For SFY 2019-20, the reimbursement rate add-on is fixed. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, A0433, and A0434 is $339.00, and for CPT Code A0225 is $400.72. The add-on is paid for each eligible CPT Code on a per-claim basis.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

Service Code	Description	Current Payment*	Add On Amount	Resulting Total Payment
A0429	Basic Life Support, Emergency	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00
A0434	Specialty Care Transport	$118.20	$220.80	$339.00
A0225	Neonatal Emergency Transport	$179.92	$220.80	$400.72

*These are the base rates associated with these codes, but are subject to further adjustments pursuant to the State Plan.

The resulting total payment amount as listed in the table above for the applicable CPT Code is considered the Rogers rate, which managed care organizations shall pay noncontract managed care emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code, for each state fiscal year the FFS reimbursement rate add-on is effective.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

Contact

Michelle Laughlin, Executive Director, Network Operations (714) 246-8400
Nancy Huang, Interim Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the OneCare Connect Health Network contracts with AltaMed Health Services Corporation to:

i. Extend the OneCare Connect Health Network contract through and including December 31, 2020;
ii. Add any necessary language provisions required based on the Three-Way Cal MediConnect contract (Three-Way Agreement) between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements, including language reflecting changes related to the Merit-based Incentive Payments System (MIPS) program; and
iii. Clarify access standards for prenatal care.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (CMC) OneCare Connect beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

Cal MediConnect was launched in 2014 as a three-year demonstration program implemented across eight counties. OneCare Connect (OCC) was launched July 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated Health Networks to manage services to the network's assigned membership.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019. At its November 2018 meeting, the Board authorized CalOptima to extend the Health Network contracts for one year through December 31, 2019.
At its October 3, 2019 meeting, the Board authorized execution of the newest version of the three-way agreement, which became effective September 1, 2019. Among the key changes of the new agreement was extension of the Cal MediConnect demonstration period through, December 31, 2022, in one-year

terms. In accordance with this change, staff is seeking authorization to extend the Health Network agreements for an additional year through December 31, 2020.

Discussion

Language Provisions; Agreement with CMS and DHCS

Contract amendments will be required to include provisions to address technical revisions and any other new/revised requirements from the new Three-Way Agreement that are applicable to the OneCare Connect Health Networks. To be in compliance with the most current version of the Three-Way Agreement received from DHCS, effective September 1, 2019, staff seeks authority to amend OneCare Connect Health Network contracts to ensure contracted OCC Health Networks ensure that providers are enrolled with DHCS as Medicaid providers consistent with all Medicaid enrollment requirements. Other changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Merit-based Incentive Payment Systems (MIPS)

In accordance with the Medicare Access and CHIP Reauthorization Act of 2015 Quality Payment Program memorandum and CalOptima Policies and Procedures, Health Networks implemented the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. This provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Payment to health networks is contingent upon annual receipt of their provider payment adjustment confirmation report, which identifies and reports all claims qualifying for MIPS payment adjustments. Health Networks are required to submit their adjustment reports on an annual basis, starting July 2020. For dates of service January 1, 2019 through December 31, 2019, payment year is 2021. Staff seeks authority to amend contracts to include language in support of the MIPS payment adjustments to the OCC Health Networks to remain in compliance with this CMS-mandated program.

Access Standards for Prenatal Care

As it relates to maternity services and access standards for prenatal care, the OneCare Connect Contract will be updated to be consistent with CalOptima's Medi-Cal Health Network contracts. The Medi-Cal Health Network contract language ensures that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for prenatal services and ensure that Physician Groups have a process in place for follow-up on Member missed appointments.

Summary of Recommendations

Staff seeks Board authorization to amend the Health Network agreements as needed to extend and add any necessary language provisions required by the Three-Way Agreement, and to include language supporting the provision for MIPS, ACOG and GEMT.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect Health Network capitation expenses of $131 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The

recommended action to renew the existing Health Network contracts through June 30, 2020 is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extensions, in the CalOptima FY 2020-21 Operating Budget.

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OCC members is maintained, allows flexibility to modify OCC Health Network contracts as needed based on CalOptima's Three-Way Agreement with DHCS and CMS, support CalOptima's payment obligations under the MIPS program, and ensure access standards for prenatal care are aligned with the most current ACOG standards and guidelines.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated December 5, 2013; Consider Participation in the Cal MediConnect Program
3. Board Action dated September 7, 2017; Authorize and Direct Execution of a New Three-Way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program
4. Board Action dated November 1, 2018; Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts
5. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
6. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
7. CMS Release of 2019 MIPS Payment Adjustment Data File

/s/ Michael Schrader — *10/30/2019*

Authorized Signature — **Date**

AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. C. Consider Participation in the Cal MediConnect Program

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400
Patti McFarland, Chief Financial Officer, (714) 246-8400

Recommended Actions
Consider the following required actions to participate in the Cal MediConnect Program:
1. Authorize and Direct the Chairman of the Board of Directors to Execute the Three-Way Agreement between the California DHCS, CMS and CalOptima for Cal MediConnect, subject to the interim final rates that will not harm the financial viability of CalOptima and reasonable and expected requirements related to operations and reporting;
2. Authorize and Direct the Chairman of the Board of Directors to Execute the California Department of Social Services' (CDSS) Contract for In-Home Supportive Services (IHSS);
3. Approve Revisions Related to Cal MediConnect to CalOptima's Fiscal Year (FY) 2013-14 Budget; and
4. Authorize the CEO to develop and/or update policies necessary to meet Cal MediConnect participation requirements and implement the program's benefit set.

Background
In June 2012, Senate Bill 1008 (2012) and SB 1036 (2012) authorized the Coordinated Care Initiative (CCI). The CCI is composed of two (2) key components that will work in tandem to improve care coordination and integration.

1. Cal MediConnect: No sooner than April 1, 2014, the state will begin a three (3) year federal-state demonstration program in eight (8) counties. Individuals with Medicare and Medi-Cal (i.e., dual eligible beneficiaries) will receive coordinated medical, behavioral health, institutional long-term care, and home and community based services through a single Medi-Cal managed care plan. The participating counties are: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside, and San Bernardino.

2. Managed Medi-Cal Long-Term Supports and Services (MLTSS): No sooner than April 1, 2014, all Medi-Cal beneficiaries, including dual eligible beneficiaries, will receive long-term services and supports and Medi-Cal wrap-around benefits through a Medi-Cal managed care plan. MLTSS includes institutional long-term care, Community Based Adult Services, Multipurpose Senior Services Program, and IHSS.

   As a County Organized Health System (COHS), CalOptima already serves dual eligible beneficiaries, and provides Medi-Cal wrap-around services to members. In addition, pursuant to SB 94 (2013), DHCS separated the MLTSS component from the Cal MediConnect program. Medi-Cal managed care plans will provide MLTSS as a Medi-Cal benefit to all enrollees even if Cal Medi-Connect does not move forward.

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DHCS initially proposed to implement Cal MediConnect no sooner than January 1, 2014. However, DHCS revised the timeline several times to accommodate ongoing negotiations with CMS and to resolve other implementation issues. On August 13, 2013, DHCS formally announced that Cal MediConnect will begin no sooner than April 1, 2014. Initial enrollment will occur on a passive enrollment basis for a twelve (12) month period, based on the eligible beneficiary's birthday month.

CalOptima's FY 2013-14 Operating Budget projected an increased enrollment of 27,000 members from the Cal MediConnect program through June 30, 2014. Staff will make a downward adjustment to the membership projection due to the delayed implementation date, and anticipates approximately 3,700 members will be passively enrolled each month. Staff will implement strategies to minimize the opt-out rate of the Cal MediConnect program.

The Demonstration Years for the Cal MediConnect program are as follows:

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

On May 3, 2012, your Board approved a pre-implementation budget for the CCI of $373,994 to proceed with the application process to participate in the program. The funds were used to support travel and training, consultant fees, limited term staffing, and outreach and engagement. The budget was for the period of May 3, 2012, through August 31, 2012.

On January 3, 2013, your Board approved additional funding to continue pre-implementation planning for the CCI of $615,000 for a total of $988,994. The funds were used to support professional fees and staffing. To date, approximately ninety-five percent (95%) of the pre-implementation funds have been spent. Based on Board approval, staff has completed all state and federal applications and additional requests, including but not limited to:

Key Deliverables	Date
DHCS Request for Solutions	February 23, 2012
CMS Capitated Financial Alignment Demonstration application	May 23, 2012
Proposed Model of Care	June 29, 2012
Proposed Medication Management Therapy Program	May 6, 2013
Proposed Part D Formulary	May 31, 2013
Proposed Plan Benefit Package	June 3, 2013
Revised Health Service Delivery Tables for Network Validation	June 26, 2013

Key steps and milestones for the Cal MediConnect program are as follows:

Key Steps and Milestones	Date
Finalize Memorandum of Understanding (MOU) (CMS and DHCS)	Executed March 27, 2013

Key Steps and Milestones	Date
Develop final capitation rates	Ongoing since April 23, 2013
Conduct joint readiness assessments (CMS and DHCS)	Initiated March 2013 and ongoing through December 2013 - Desk Review: April 19, 2013 - On-site visit: July 25-26, 2013 - Remote Systems Testing: October 21, 2013 - Network Validation: October 28, 2013 - Pre-Enrollment Validation: November 20, 2013 - Final Readiness report to be issued mid-December 2013
Execute MOUs with relevant county agencies	Completed in July and August 2013
Sign Three-Way contract	December 13, 2013 (electronic signature) December 16, 2013 (hard copy signature)
Sign CDSS contract for IHSS services	Mid-December 2013 (anticipated)
Finalize Plan Benefit Package in CMS system	Mid-December 2013
Implement Cal MediConnect	No sooner than April 1, 2014

On June 6, 2013, your Board approved CalOptima's FY 2013-14 Operating Budget. Staff clarified that the operating budget did not include infrastructure and implementation funding for the Duals Demonstration (i.e., the Cal MediConnect program), and that Staff would present the budget as a separate Board action.

Discussion

Both DHCS and CMS are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of Cal MediConnect. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted, as noted above, from the prior dates shared with the Board in previous meetings. Staff participated in the on-site readiness review July 25-26, 2013.

The next key step is for CalOptima to sign the Three-Way Agreement with CMS and DHCS. Recently, DHCS notified participating plans that the final date by which CMS will require execution of the Agreement is December 10, 2013. Plans, including CalOptima, received the "final" Three-Way Agreement on November 6, 2013 and were advised that they would not be able to negotiate changes to the Agreement. Although the document contains a number of terms that are currently in other program agreements, this was the first time that plans received the document which contains new Cal MediConnect program requirements, Plans had approximately one week to review the document and submit a list of "significant concerns" to the Agreement. DHCS held a conference call with plans on November 20, 2013 to discuss the comments plans submitted. On the call, the DHCS provided clarification on certain terms, but essentially reiterated that the "final" version was, in fact, final. CMS and DHCS issued interim final rates in late October for plans' thirty (30) day review. Additionally, DHCS has indicated that rates may be subject to additional minor revisions prior to the final execution of the Agreement.

Three-Way Cal MediConnect Agreement

The Agreement between DHCS, CMS, and CalOptima outlines the respective obligations for each party to implement the Cal MediConnect program in Orange County. The Agreement contains provisions for CMS

and DHCS to evaluate CalOptima's performance as a Cal MediConnect participating plan, including adherence to federal Medicare and Medicaid laws.

Below are some areas within the Agreement that will have a significant operational and financial impact:

Requirement / Area of Concern	Impact
Benefits and funding streams	The Agreement reflects continued fragmentation of Medicare and Medi-Cal benefits, services, and funding streams will pose operational challenges. Full integration will likely not occur until year 2 of the demonstration.
Care coordination	The Agreement includes extensive care coordination requirements that conflict with the existing Medicare requirements for a plan's Model of Care are included in the Agreement. Specifically, the ten (10) day timeframe to develop Individualized Care Plans (ICPs) for members after completion of the Health Risk Assessment (HRA) is insufficient.
Rate dispute process	The Agreement excludes rates from the dispute process. Requiring participating plans to waive their legal rights to dispute a rate that may be unreasonable or actuarially unsound is particularly problematic in year 2 and 3 of the demonstration.
Quality withholds	There is a lack of specific information on the quality withhold metrics, and how plans will be measured for purposes of earning back the withheld amount based on performance. The agreement lacks a process for plans to provide meaningful input on the performance metrics that will be tied to the quality withholds for each Demonstration year.
IHSS	Plans are required to assume full risk for IHSS provider payments (i.e., wages and benefits, such as health insurance). The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December. CalOptima Board of Directors would likely have to make a "go / no-go" decision on the 3-way contract for Cal MediConnect in December without the opportunity to review the CDSS contract.
After-hours call capacity	Plans cannot leverage current 24-hour Nurse Advice Lines to meet the after-hours call capacity requirement as the after-hours call service needs to be staffed either by a physician or an appropriate licensed professional under his or her supervision.

Requirement / Area of Concern	Impact
Pending contracts and regulatory guidance	The Agreement incorporates requirements to comply with unissued CMS/DHCS guidance. These references in the Agreement are broad and are not limited to indicating that the guidance will do no more than interpret current requirements under State and Federal laws.
Advisory Committee	Requires the formation of a new Advisory Committee to the Board of Directors, which must consist of not more than eleven (11) people, and no less than fifty percent (50%) of the membership of the advisory committee shall be individuals who are users of personal assistance paid for through public or private funds or recipients of IHSS services.

Other issues related to the Three-Way Agreement for Cal MediConnect include:

- Lack of specific information on IHSS;
  - Data sharing issues with the California Department of Social Services (CDSS) for IHSS; and
  - Contract terms for agreement with CDSS. The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December.

- Reporting requirements not yet specified (e.g., network adequacy, performance measures).

Revisions to CalOptima's FY 2013-14 Implementation, Operating, and Capital Budgets
Staff is submitting revisions to the FY 2013-14 Implementation, Operating, and Capital Budget to the BOD for approval with assumptions based on currently available information.

Proposed Budget 1/1/14 – 6/30/14			
	Implementation	**Operational**	**Total**
Average Monthly Enrollment	N/A	7,118	7,118
Revenue	$0	$43,130,331	$43,130,331
Medical Costs	$2,845,316	$38,414,385	$41,259,701
Administrative Costs	$2,879,267	$4,069,166	$6,948,433
Operating Income/(Loss)	($5,724,583)	$646,780	($5,077,803)
Medical Loss Ratio (MLR)	N/A	89.1%	95.7%
Administrative Loss Ratio (ALR)	N/A	9.4%	16.1%
Capital – Hardware/Software			$1,100,000

Enrollment Assumptions:
- Begins April 1, 2014 with an estimated 3,680 members
- Assumes a pre-enrollment opt-out rate of 20% and disenrollment rate of 5%

- CY 2014 enrollment will consist of FFS Medicare membership, since Medicare Advantage enrollees are allowed to stay with existing plan through Dec 2014

Revenue Assumptions:
- Bases Medicare rates on draft rates provided in October 2013
- Bases Medi-Cal rates on draft rates provided on November 20, 2013
- Estimates total revenue of $2,019.74 per member per month
- Medicare Part A/B and Part D rates utilizes a base rate and applies a risk adjustment factor (similar to OneCare revenue)
- Medi-Cal rate is a blended rate of four population cohorts: LTC, HCBS High, HCBS Low, and Community Well
- Adjusts rates for savings targets that escalate from 1.4% to 5.5% over the next three and a half years

Medical Cost Assumptions:
- Assumes an average provider capitation rate of 37.5% of Medicare Part A/B premium
- Uses current OneCare medical utilization and unit cost rates as a proxy
- Assumes an MLR of 85.3% on prescription drug benefits
- Assumes an MLR of 90.3% on Medi-Cal wrap-around benefits
- Excludes supplemental benefits with the exception of mental health and transportation services
- Includes program guidelines that require higher levels of Case Management and Health Services
- Estimates eighty-two (82) FTE's are scheduled over the remainder of the year

Administrative Cost Assumptions:
- Includes implementation costs of $5.7 million to prepare the organizations processes, policies, and staff for a targeted go-live date of April 1, 2014
- Program guidelines specify staffing requirements, such as Compliance and Customer Service
- Estimates sixty-three (63) FTE's are scheduled over the remainder of the year
- First twelve (12) months of the program will require higher than standard level of cost for initial items such as member and provider mailings as well as staff recruitment and training. These costs are staged in to occur approximately three (3) months prior to the member enrollment.

Capital Assumptions:
- Includes hardware and software required to support the increase in staffing and projected membership population

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
CCMS (Medical Database)	$ 222,300	20%
Facets Upgrades	204,300	19%
Backup Environment	67,240	6%
Core Infrastructure	58,020	5%
Data Warehouse	43,000	4%

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
Misc (Network Costs)	505,140	46%
Total	$ 1,100,000	100%

The Proposed budget includes hardware, software, and professional fees.

Next Steps:
After receipt and review of the Three-Way Agreement and analysis of the interim final rates, Staff recommends the BOD to authorize the Chairman to execute the Three-Way Agreement for CalOptima to participate in Cal MediConnect.

Concurrently, Staff will continue to prepare for the implementation of Cal MediConnect and Managed MLTSS.

Approval of the proposed actions and the Board Chair's execution of the three-way agreement with CMS and DHCS will commit CalOptima to participating in the Cal MediConnect Program.

Fiscal Impact
As outlined above, the proposed revisions to the CalOptima FY 2013-14 Implementation and Operating Budget reflect a deficit of $5.1 million and a Capital Budget of $1.1 million.

Rationale for Recommendation
The DHCS proposal to implement the CCI aligns with CalOptima's long standing commitment to better integrate acute and long term care services. This integration initiative provides CalOptima an opportunity to work with community stakeholders to design a system that fully integrates the administrative and financial responsibilities for Medi-Cal and Medicare covered services and achieve its acute and long term care integration goals.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/27/2013*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

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- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: January 8, 2019

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer R. Shapiro, Acting Director, Medicare Plan Payment Group

SUBJECT: **Release of 2019 MIPS Payment Adjustment Data File**

The Centers for Medicare & Medicaid Services (CMS) has uploaded to the Health Plan Management System (HPMS) the Merit-based Incentive Payment System (MIPS) Payment Adjustment Data File for payment year 2019. Medicare Advantage organizations (MAOs) can use the information in the file to determine the amount of the MIPS payment adjustment that applies to their payments for Medicare Part B covered professional services furnished by out-of-network MIPS eligible clinicians.

For guidance on when and how the MIPS payments apply to MAOs' payments to MIPS eligible clinicians, please see the April 27, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments" and the November 8, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance."

File Access

The 2019 MIPS Payment Adjustment Data File has been added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). After navigating to the "Incentive Payments" section, a user may download the file by selecting "MIPS Payment Adjustment Data File" under Step One, "2019" under Step Two, and "Download" under Step Three.

Due to the sensitivity of some of the information provided in the file, only the MAO's Medicare Compliance Officer will be able to access and download it. The Compliance Officer must be a registered HPMS user in order to obtain the file.

Identifying the Applicable MIPS Adjustment Percentage

The MIPS Payment Adjustment Data File consists of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)

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- MIPS adjustment percentage
- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see the attached Appendix.

An MAO can identify the applicable MIPS adjustment percentage for a MIPS eligible clinician by matching the clinician's billing TIN/NPI combination to a TIN/NPI combination in the MIPS Payment Adjustment Data File. If an exact match for the billing TIN/NPI combination does not appear in the data file, the MAO should determine whether the NPI appears in combination with another TIN and, if so, apply the MIPS adjustment percentage associated with that TIN/NPI combination. If the NPI appears in more than one TIN/NPI combination in the data file, the MAO should apply the MIPS adjustment percentage for the TIN/NPI combination that results in the greatest total payment amount.

Additional Information

If you encounter technical difficulties when downloading the MIPS Payment Adjustment Data File from HPMS, you may contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028.

If the "Incentive Payments" hyperlink does not appear in the HPMS Data Extract Facility, you must send a request for additional access to hpms_access@cms.hhs.gov. Please note that information in the MIPS Payment Adjustment Data File is considered sensitive and may require additional levels of approval.

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

Appendix

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Policy:	HH.2005Δ
Title:	**Corrective Action Plan**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/ Richard Sanchez 12/07/2020*
Effective Date:	11/01/1998
Revised Date:	12/03/2020

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE
- ☐ Administrative

I. PURPOSE

This policy defines the requirements for CalOptima and its First Tier, Downstream, and Related Entities (FDRs) for development and submission of an Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) for areas of non-compliant performance, as identified by CalOptima's Office of Compliance.

II. POLICY

A. CalOptima's Office of Compliance shall conduct Auditing, operational Monitoring, and investigations of internal CalOptima departments and its FDRs to ensure compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements related to CalOptima programs.

B. CalOptima's Office of Compliance may require that an internal department or FDR develop an ICAP or CAP response based on the identified area(s) of non-compliance.

C. CalOptima's Office of Compliance shall require CalOptima internal departments and FDRs to bring their operations into full compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements, which CalOptima or its regulators have identified as non-compliant, within time frames established by CalOptima's Office of Compliance.

D. An internal department or FDR shall develop, submit, and take corrective action under an approved ICAP or CAP response in the time and manner required by CalOptima's Office of Compliance.

1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP or CAP request may lead to further action.

2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP, or CAP, request may lead to further action. CalOptima may impose Sanctions for the underlying non-compliant performance that gave rise to the ICAP or CAP request, or the failure to develop, submit, and meet the requirements of the ICAP or CAP request, in accordance with CalOptima Policy HH.2002Δ: Sanctions.

III. PROCEDURE

A. Basis for an ICAP or CAP

1. CalOptima's Office of Compliance shall routinely Monitor performance metrics, conduct routine, or focused, Audits, and conduct ongoing Monitoring and investigations of reported non-compliance for internal departments, or FDRs, through a variety of mechanisms.

    a. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of Audits conducted by federal and state regulatory agencies, including, but not limited to the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Managed Health Care (DMHC).

    b. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of an ICAP/CAP request, or other corrective action, that CalOptima receives from a federal or state regulatory agency that is directly related to the operations of an internal department or FDR.

2. In the event that CalOptima's Office of Compliance determines an internal department, or FDR, has failed to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements, the Office of Compliance may issue an ICAP, or CAP request, to address the problem. CalOptima's Office of Compliance shall coordinate its efforts with CalOptima's Human Resources Department in the event that an ICAP or CAP potentially warrants Employee disciplinary action.

B. ICAP and CAP Issuance and Requirements

1. CalOptima's Office of Compliance shall utilize a standardized ICAP and CAP request template.

2. Non-compliance with specific requirements that have the potential to cause significant Member harm, or place CalOptima's accreditation, participation, and/or contractual status with regulatory agencies in jeopardy will require an ICAP response.

    a. If the finding requires an ICAP request, as determined by CalOptima's Office of Compliance, the internal department or FDR is required to cease non-compliant activities within two (2) business days of receiving the ICAP request.

    b. The internal department or FDR shall provide a written response within three (3) business days of receiving an ICAP request, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the ICAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima's Office of Compliance.

3. A CAP request is the result of material non-compliance with specific requirements that does not rise to the level of an ICAP request.

    a. The internal department or FDR is required to respond to the CAP request within fourteen (14) calendar days. CalOptima's Compliance Officer or Designee may authorize extensions to this timeline on a case-by-case basis. Following the acceptance of the CAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima's Office of Compliance.

4. An ICAP or CAP response shall include the following elements:

a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training, and systems that failed;

b. Steps taken to resolve the deficiency;

c. Steps taken to avoid reoccurrence;

d. Method for implementation and completion of ICAP response or CAP response;

e. Individual(s) responsible for implementation of the ICAP response or CAP response;

f. An attestation by the internal department or FDR conveying a plan to remedy its identified deficiencies; and

g. ICAP response or CAP response completion date(s), as applicable.

C. Unacceptable Resolution to an ICAP or CAP

1. If the resolution to the deficiency is unacceptable or the internal department or FDR fails to respond, CalOptima's Office of Compliance shall issue a written notice to the internal department or the FDR, which shall include:

a. A summary of previous outreach and required action(s);

b. An explanation of why that the resolution was not acceptable, or why a response was not received;

c. A revised response timeline of two (2) business days for an ICAP;

i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or Designee.

d. A revised response timeline of five (5) business days for a CAP;

i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or Designee.

e. Explain the possible consequences, specific to the nature of the issue and degree of completeness in accordance with CalOptima Policy HH.2002Δ: Sanctions;

f. Possibility of escalating to the department's Chief, or the FDR's Chief Executive Officer (CEO) or their Designee; and

g. Possibility of referral to the Audit & Oversight Committee and the Compliance Committee.

D. Acceptable Resolution with ICAP or CAP Requirements

1. A response may be accepted once all requirements outlined in Section III.B.4. of this Policy are fulfilled. If an ICAP or CAP response requires Monitoring or a focused Audit, the ICAP or CAP response shall not be closed until the remediation(s) implemented have been validated by the Office of Compliance and demonstrate that the issue will not recur.

a. A response may be accepted and closed simultaneously if Monitoring or a focused Audit is not required.

2. If the resolution to the deficiency is deemed acceptable by CalOptima's Compliance Officer or Designee, CalOptima's Office of Compliance may issue a written notification of acceptance, which shall include:

   a. An acknowledgement of acceptance;

   b. A description of follow up actions which shall include, but is not limited to:

      i. Submission of finalized documentation; and/or

      ii. Focused Audit, as described in Section III.E. of this Policy; and/or

      iii. Monitoring, as deemed appropriate by CalOptima's Office of Compliance, and as described in Section III.F. of this Policy.

3. If the resolution to the deficiency is accepted and deemed sufficient by CalOptima's Compliance Officer or Designee, CalOptima's Office of Compliance shall issue a written notification of closure, which shall include:

   a. An acknowledgement of closure;

   b. The effective date of closure; and

   c. Consequences of repeat deficiencies.

E. Focused Audits

1. CalOptima's Office of Compliance may conduct a focused Audit of an internal department or FDR to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima's Office of Compliance shall notify the internal department or FDR of the scope, Audit period, and Audit deliverables that shall be required to complete the focused Audit.

3. CalOptima's Office of Compliance may continue to Monitor and/or Audit an internal department or FDR for performance of issues and/or functions related to the ICAP or CAP request.

F. Monitoring Period

1. CalOptima's Office of Compliance may conduct Monitoring of the internal department's or FDR's resolution to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima's Office of Compliance shall Monitor the resolution for a predetermined time frame, as established by CalOptima's Office of Compliance.

3. CalOptima's Office of Compliance shall notify the internal department, or FDR, of the scope, Monitoring period, and deliverables that shall be required to complete the Monitoring.

4. CalOptima's Office of Compliance may continue to Monitor and/or Audit an internal department's or FDR's performance of issues and/or functions related to the ICAP or CAP request.

G. Failure to Maintain Adequate Resolution

1. If during the Monitoring period or the focused Audit the internal department or FDR fails to maintain the remedies in place, CalOptima's Office of Compliance may issue the internal department or FDR an ICAP or CAP request, as appropriate.

2. If an ICAP request is issued, the internal department or FDR shall be required to resolve the issue within two (2) business days from the re-issuance of the finding.

   a. Extensions to this timeline may be authorized on a case-by-case basis by the Compliance Officer, or Designee.

3. The ICAP request shall require the information as described in Section III.B.4. of this Policy.

H. ICAP and CAP Tracking and Reporting

1. CalOptima's Office of Compliance shall track all CAP and ICAP requests issued utilizing a standardized tool.

2. CalOptima's Office of Compliance shall report the status of all CAP/ICAP requests to the Audit & Oversight Committee and the Compliance Committee.

3. In the event that CalOptima's Office of Compliance issues an ICAP request with respect to the CalOptima Medi-Cal Program, the Regulatory Affairs & Compliance Department shall report the issue to CalOptima's DHCS Contract Manager for Medi-Cal within three (3) business days of issuance.

4. If CalOptima's internal department, or FDR, has repeat deficiencies, the issue(s) shall be reported to the Audit & Oversight Committee and the Compliance Committee by the Office of Compliance for further action.

IV. ATTACHMENT(S)

A. ICAP/CAP Request Template

V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy HH.2002Δ: Sanctions
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Department of Health Care Services (DHCS) All Plan Letter 17-004: Subcontractual Relationships and Delegation
H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9

J. Title 22, California Code of Regulations (CCR), §51301 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
08/02/2018	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1998	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	10/01/2002	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Effective	08/01/2005	MA.9104	Corrective Action Plan	OneCare
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	08/01/2008	MA.9104	Corrective Action Plan	OneCare
Revised	04/01/2013	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare
Revised	04/01/2014	MA.9104	Corrective Action Plan	OneCare
Revised	12/01/2014	MA.9104	Corrective Action Plan	Cal MediConnect OneCare PACE
Revised	09/01/2015	HH.2005	Corrective Action Plan	Medi-Cal
Revised	09/01/2015	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	08/02/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Audit & Oversight Committee	A subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in the AOC charter.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier Entities and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
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.
Employee	For purposes of this policy, any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDRs)	First Tier Entity: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program. Downstream Entity: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services. Related Entity: Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two-thousand five-hundred dollars ($2,**500)** during a contract period.

Term	Definition
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Immediate Corrective Action Plan (ICAP) Request	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	A beneficiary who is enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a First Tier Entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

AMENDMENT {XXXXXX} TO

CAL MEDICONNECT PHYSICIAN GROUP SERVICES CONTRACT

This Amendment {XXXXX} to the Cal MediConnect Physician Group Services Contract ("Amendment") is effective as of January 1, 2022, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, {_____} ("Physician Group"), with respect to the following facts:

RECITALS

A. Physician Group and CalOptima have entered into a Cal MediConnect Physician Group Services Contract ("Contract") for the provision of specified covered services to CalOptima members in identified CalOptima Programs.

B. CalOptima and Physician Group desire to amend the Contract to extend the term of the Contract and revise the Corrective Action Plan time frame.

NOW, THEREFORE, the parties agree as follows:

1. Section 11.1 "Term of the Contract" shall be deleted in its entirety and replaced with the following:

   "11.1 **Term of Contract.** This Contract will commence on June 1, 2015 (Effective Date") and will remain in effect until December 31, 2022."

2. Section 11.3.1 shall be deleted in its entirety and replace with the following:

   "11.3.1 CalOptima may require a CAP if it receives a substantiated complaint or grievance related to the Physician Group or any Downstream Entities' non-compliance with statutory, regulatory, contractual, policy or other requirements in accordance with the CAP timing, content and other requirements of CalOptima's corrective action plan and other applicable policies.

3. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS THEREOF, CalOptima and {Insert HN Name Here} have executed this Amendment {Insert Amendment # Here}:

FOR PHYSICIAN GROUP:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	_____
PRINT NAME	PRINT NAME
_____	_____
TITLE	TITLE
_____	_____
DATE	DATE

Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

20. Consider Authorizing Amendments to Extend the OneCare Connect Cal MediConnect Plan Health Network Contract for AltaMed Health Services Corporation and Align the Corrective Action Plan Section of the Contract with Current Policy

Contacts

Yunkyung Kim, Chief Operating Officer, 714-246-8408
Michelle Laughlin, Executive Director Network Operations, 657-900-1116

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the OneCareConnect health network contract for AltaMed Health Services Corporation (AltaMed) as follows:

1. Exercise the final one-year extension option of the health network contracts agreements through December 31, 2022; and
2. Align the Corrective Action Plan section of the contract with current policy

Background

In 2014, the State launched Cal MediConnect (CMC), designed to serve members eligible for both Medicare and Medi-Cal, in a dual health plan covering medical, prescription drug, and long-term services and support. CMC was initially launched as a three-year demonstration program across eight counties in California. In Orange County, CalOptima provides health care services to CMC beneficiaries via OneCare Connect (OCC). OCC was established with authorization through a three-way contract between CalOptima, the Department of Health Care Services (DHCS), and the Centers for Medicare & Medicaid Services (CMS). The CalOptima Board of Directors (Board) initially authorized this three-way contract at its December 5, 2013, meeting, with CalOptima providing OCC benefits as of July 1, 2015.

At its September 2017 meeting, the Board authorized the execution of a new three-way contract between CalOptima, CMS and DHCS to extend OCC for an additional two years, through December 31, 2019. At its October 3, 2019, meeting, the Board authorized execution of a third three-way contract, which became effective September 1, 2019. Among key changes it included was the extension of the CMC Demonstration Period through December 31, 2022, renewable in one-year terms. With the sunsetting of the Cal MediConnect demonstration program at the end of calendar year 2022, OCC will sunset. CalOptima plans to transition all OCC members as of January 1, 2023, to OneCare (HMO SNP). This includes expanding the OneCare provider network to accommodate the increased membership that will take effect as OCC ends.

Effective July 1, 2015, CalOptima contracted with its OCC delegated health networks for an initial period through December 31, 2017. The Board approved an amendment for a one-year extension, to be effective January 1, 2018, with option to extend an additional year, ending December 31, 2019. The Board approved two additional amendments to extend the contract,

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to be effective January 1, 2020, through December 31, 2020, as well as January 1, 2021 through December 31, 2021.

Discussion

Health Network Contract Extensions
With OCC entering its third year of the three-year extension allowance for the three-way contract with DHCS and CMS, CalOptima needs to maintain its contractual relationships with the health networks providing health care services to OCC members. CalOptima contracts with AltaMed for OCC, under the Shared Risk (SR), contract model. In coordination with the extension of the demonstration period, staff is seeking authorization to extend the AltaMed's health network contract through December 31, 2022.

Align Corrective Action Plan Section of the Contract with Current Policy
CalOptima Policy HH.2005 "Corrective Action Plan" serves as a guideline for addressing Corrective Action Plans (CAPs) issued by CalOptima's Office of Compliance. Previously there was a 30-calendar day period allowed for the internal department or First Tier, Downstream, and Related Entities to respond to a CAP. As a result of policy updates, this response time has been modified to 14 calendar days. Staff recommend amending the OCC health network contract with AltaMed to align the corrective action plan section of the contract with current policy.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2021-22 Operating Budget approved by the Board on June 3, 2021, incorporated total OCC health network capitation expenses of $146.8 million. The recommended action to extend the existing health network contracts through June 30, 2022, is a budgeted item, with no additional fiscal impact expected. Management plans to include revenue and expenses for the period of July 1, 2022, through December 31, 2022, as related to the proposed contract extensions, in the CalOptima FY 2022-23 Operating Budget.

The recommended action to amend the OCC Health Network contracts related to CAP response time is operational in nature, with no anticipated fiscal impact beyond what was incorporated in the CalOptima FY 2021-22 Operating Budget.

Rationale for Recommendation

The recommended contract changes are intended to ensure that the contractual relationships with the AltaMed health network is maintained and that the contract is aligned with current policy.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated November 5, 2020: Consider Authorizing Extension of, and Amendments to, the Cal MediConnect (OneCare Connect) Health Network Contracts
3. Previous Board Action dated November 7, 2019: Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, except those associated with AltaMed Health Services Corporation, to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services
4. Previous Board Action dated November 7, 2019: Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services
5. CalOptima Policy & Procedure HH.2005: Corrective Action Plan
6. Proposed OneCare Connect Health Network Contract Amendment

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
November 5, 2020	Consider Authorizing Extension of, and Amendments to, the Cal MediConnect (OneCare Connect) Health Network Contracts		
November 7, 2019	Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, Except Those Associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contract to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services		
November 7, 2019	Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts Associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contract to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services		
November 1, 2018	Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts		

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September 7, 2017	Authorize and Direct Execution of a New Three-Way Contract Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program		
December 5, 2013	Consider Participation in the Cal MediConnect Program		

/s Richard Sanchez *10/28/2021*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
13. Consider Authorizing Extension of, and Amendments to, the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Action
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the OneCare Connect Health Network contracts to extend the term through December 31, 2021 and to address modified and additional terms.

Background
In 2014, the State launched Cal MediConnect (CMC), designed to serve members eligible for both Medicare and Medi-Cal, in a dual health plan covering medical, prescription drug, and long-term services and support. CMC was initially launched as a three-year demonstration program across eight counties in California. At the local level, CalOptima provides health care services to CMC beneficiaries in Orange County, via its OneCare Connect (OCC) program. OCC was executed with authorization through a three-way contract between CalOptima, the Department of Health Care Services (DHCS), and the Centers for Medicare & Medicaid Services (CMS). The CalOptima Board of Directors (Board) initially authorized this agreement at its December 5, 2013 meeting, with CalOptima providing OCC benefits as of July 1, 2015.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC/OCC program for an additional two years, through December 31, 2019. At its October 3, 2019 meeting, the Board authorized execution of a third Three-Way agreement, which became effective September 1, 2019. Among key changes it included the extension of the CMC Demonstration Period through December 31, 2022, renewable in one-year terms.

In support of CMC/OCC, CalOptima has contracted with its delegated Health Networks to manage health care services for OCC members as of the program's launch. At the Board's November 2018 meeting, staff received authorization to extend the Health Network contracts for one year, through December 31, 2019. On November 7, 2019, the Board authorized staff to exercise the first of three one-year (1) extension options in each of the Health Network contracts, extending them through December 31, 2020.

Discussion

Health Network Contract Extensions
With OCC entering its second year of the three-year extension granted for the Three-Way agreement with DHCS, CalOptima needs to maintain its contractual relationship with the Health Networks providing health care services to OCC members. In coordination with the extension of the

demonstration period, staff is seeking authorization to exercise a one-year extension option of the Health Networks' agreements through December 31, 2021.

Capitation Rate Change for Hospital and Shared Risk Pool Funding
Staff seeks authorization to amend the OCC Health Network contracts to adjust the Hospital capitation rates and Shared Risk Pool funding to more appropriately reflect delegated risk assigned to Health Networks, and as included in the CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020.

Division of Financial Responsibility (DOFR)
Staff seeks authorization to implement changes to the DOFR, including changing coverage of Methadone Clinic services to CalOptima Responsibility as a Medicare covered service. Additionally, Worldwide Coverage has been added as a Medicare covered service.

Change Timeframe for Termination Without Cause
Staff also seeks authorization to amend the notice period for Termination Without Cause from 120 days to 180 days. This change allows for a more appropriate time frame related to activities involved with a termination including, but not limited to, reassignment of members, issuing new ID cards, member education, and operational systems-related changes.

Fiscal Impact
The CalOptima FY 2020-21 Operating Budget approved by the Board on June 4, 2020 incorporated OCC Health Network capitation expenses of $133 million, including updated Hospital capitation rates and their associated impact to Shared Risk Pool funding. The recommended action to extend the existing Health Network contracts through June 30, 2021 is a budgeted item, with no additional fiscal impact. Management plans to include revenue and expenses for OCC for the period of July 1, 2021 through December 31, 2021, as related to the contract extensions, in the CalOptima FY 2021-22 Operating Budget.

The recommended action to amend the OCC Health Network contracts to add the recommended contract language is budget neutral. The addition of language related to the termination without cause provision is operational in nature, with no anticipated fiscal impact beyond what was incorporated in the CalOptima FY 2020-21 Operating Budget. The proposed changes to the DOFR are not anticipated to have a material impact to CalOptima's financials.

Rationale for Recommendation
The recommended contract changes are intended to ensure that the contractual relationships with the Health Networks serving CalOptima's OCC members are maintained, and that contracts are aligned with current operational procedures.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Previous Board Action dated November 7, 2019; "Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services."
3. Previous Board Action dated September 7, 2017; "Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program"
4. Previous Board Action dated November 7, 2019; "Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, except those associated with AltaMed Health Services Corporation, to Extend them and Incorporate Oher Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services"

/s/ Richard Sanchez — *10/28/2020*
Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western Medical Group	1665 Scenic Ave Dr., #100	Costa Mesa	CA	92626
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Monarch Medical Group	11 Technology Dr.	Irvine	CA	92618
Talbert Medical Group	1665 Scenic Ave Dr., Ste #100	Costa Mesa	CA	92626
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868
AltaMed Health Services	2040 Camfield Ave.	Los Angeles	CA	90040
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates	10855 Business Center Dr. Ste. C	Cypress	CA	90630
Prospect Medical Group	600 City Parkway West Ste. 800	Orange	CA	92868

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

Contact

Michelle Laughlin, Executive Director, Network Operations (714) 246-8400
Nancy Huang, Interim Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the OneCare Connect Health Network contracts with AltaMed Health Services Corporation to:

i. Extend the OneCare Connect Health Network contract through and including December 31, 2020;
ii. Add any necessary language provisions required based on the Three-Way Cal MediConnect contract (Three-Way Agreement) between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements, including language reflecting changes related to the Merit-based Incentive Payments System (MIPS) program; and
iii. Clarify access standards for prenatal care.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (CMC) OneCare Connect beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

Cal MediConnect was launched in 2014 as a three-year demonstration program implemented across eight counties. OneCare Connect (OCC) was launched July 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated Health Networks to manage services to the network's assigned membership.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019. At its November 2018 meeting, the Board authorized CalOptima to extend the Health Network contracts for one year through December 31, 2019.
At its October 3, 2019 meeting, the Board authorized execution of the newest version of the three-way agreement, which became effective September 1, 2019. Among the key changes of the new agreement was extension of the Cal MediConnect demonstration period through, December 31, 2022, in one-year

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terms. In accordance with this change, staff is seeking authorization to extend the Health Network agreements for an additional year through December 31, 2020.

Discussion

Language Provisions; Agreement with CMS and DHCS

Contract amendments will be required to include provisions to address technical revisions and any other new/revised requirements from the new Three-Way Agreement that are applicable to the OneCare Connect Health Networks. To be in compliance with the most current version of the Three-Way Agreement received from DHCS, effective September 1, 2019, staff seeks authority to amend OneCare Connect Health Network contracts to ensure contracted OCC Health Networks ensure that providers are enrolled with DHCS as Medicaid providers consistent with all Medicaid enrollment requirements. Other changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Merit-based Incentive Payment Systems (MIPS)

In accordance with the Medicare Access and CHIP Reauthorization Act of 2015 Quality Payment Program memorandum and CalOptima Policies and Procedures, Health Networks implemented the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. This provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Payment to health networks is contingent upon annual receipt of their provider payment adjustment confirmation report, which identifies and reports all claims qualifying for MIPS payment adjustments. Health Networks are required to submit their adjustment reports on an annual basis, starting July 2020. For dates of service January 1, 2019 through December 31, 2019, payment year is 2021. Staff seeks authority to amend contracts to include language in support of the MIPS payment adjustments to the OCC Health Networks to remain in compliance with this CMS-mandated program.

Access Standards for Prenatal Care

As it relates to maternity services and access standards for prenatal care, the OneCare Connect Contract will be updated to be consistent with CalOptima's Medi-Cal Health Network contracts. The Medi-Cal Health Network contract language ensures that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for prenatal services and ensure that Physician Groups have a process in place for follow-up on Member missed appointments.

Summary of Recommendations

Staff seeks Board authorization to amend the Health Network agreements as needed to extend and add any necessary language provisions required by the Three-Way Agreement, and to include language supporting the provision for MIPS, ACOG and GEMT.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect Health Network capitation expenses of $131 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The

recommended action to renew the existing Health Network contracts through June 30, 2020 is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extensions, in the CalOptima FY 2020-21 Operating Budget.

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OCC members is maintained, allows flexibility to modify OCC Health Network contracts as needed based on CalOptima's Three-Way Agreement with DHCS and CMS, support CalOptima's payment obligations under the MIPS program, and ensure access standards for prenatal care are aligned with the most current ACOG standards and guidelines.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated December 5, 2013; Consider Participation in the Cal MediConnect Program
3. Board Action dated September 7, 2017; Authorize and Direct Execution of a New Three-Way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program
4. Board Action dated November 1, 2018; Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts
5. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
6. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
7. CMS Release of 2019 MIPS Payment Adjustment Data File

/s/ Michael Schrader — *10/30/2019*

Authorized Signature — **Date**

AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. C. Consider Participation in the Cal MediConnect Program

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400
Patti McFarland, Chief Financial Officer, (714) 246-8400

Recommended Actions
Consider the following required actions to participate in the Cal MediConnect Program:
1. Authorize and Direct the Chairman of the Board of Directors to Execute the Three-Way Agreement between the California DHCS, CMS and CalOptima for Cal MediConnect, subject to the interim final rates that will not harm the financial viability of CalOptima and reasonable and expected requirements related to operations and reporting;
2. Authorize and Direct the Chairman of the Board of Directors to Execute the California Department of Social Services' (CDSS) Contract for In-Home Supportive Services (IHSS);
3. Approve Revisions Related to Cal MediConnect to CalOptima's Fiscal Year (FY) 2013-14 Budget; and
4. Authorize the CEO to develop and/or update policies necessary to meet Cal MediConnect participation requirements and implement the program's benefit set.

Background
In June 2012, Senate Bill 1008 (2012) and SB 1036 (2012) authorized the Coordinated Care Initiative (CCI). The CCI is composed of two (2) key components that will work in tandem to improve care coordination and integration.

1. Cal MediConnect: No sooner than April 1, 2014, the state will begin a three (3) year federal-state demonstration program in eight (8) counties. Individuals with Medicare and Medi-Cal (i.e., dual eligible beneficiaries) will receive coordinated medical, behavioral health, institutional long-term care, and home and community based services through a single Medi-Cal managed care plan. The participating counties are: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside, and San Bernardino.

2. Managed Medi-Cal Long-Term Supports and Services (MLTSS): No sooner than April 1, 2014, all Medi-Cal beneficiaries, including dual eligible beneficiaries, will receive long-term services and supports and Medi-Cal wrap-around benefits through a Medi-Cal managed care plan. MLTSS includes institutional long-term care, Community Based Adult Services, Multipurpose Senior Services Program, and IHSS.

   As a County Organized Health System (COHS), CalOptima already serves dual eligible beneficiaries, and provides Medi-Cal wrap-around services to members. In addition, pursuant to SB 94 (2013), DHCS separated the MLTSS component from the Cal MediConnect program. Medi-Cal managed care plans will provide MLTSS as a Medi-Cal benefit to all enrollees even if Cal Medi-Connect does not move forward.

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DHCS initially proposed to implement Cal MediConnect no sooner than January 1, 2014. However, DHCS revised the timeline several times to accommodate ongoing negotiations with CMS and to resolve other implementation issues. On August 13, 2013, DHCS formally announced that Cal MediConnect will begin no sooner than April 1, 2014. Initial enrollment will occur on a passive enrollment basis for a twelve (12) month period, based on the eligible beneficiary's birthday month.

CalOptima's FY 2013-14 Operating Budget projected an increased enrollment of 27,000 members from the Cal MediConnect program through June 30, 2014. Staff will make a downward adjustment to the membership projection due to the delayed implementation date, and anticipates approximately 3,700 members will be passively enrolled each month. Staff will implement strategies to minimize the opt-out rate of the Cal MediConnect program.

The Demonstration Years for the Cal MediConnect program are as follows:

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

On May 3, 2012, your Board approved a pre-implementation budget for the CCI of $373,994 to proceed with the application process to participate in the program. The funds were used to support travel and training, consultant fees, limited term staffing, and outreach and engagement. The budget was for the period of May 3, 2012, through August 31, 2012.

On January 3, 2013, your Board approved additional funding to continue pre-implementation planning for the CCI of $615,000 for a total of $988,994. The funds were used to support professional fees and staffing. To date, approximately ninety-five percent (95%) of the pre-implementation funds have been spent. Based on Board approval, staff has completed all state and federal applications and additional requests, including but not limited to:

Key Deliverables	Date
DHCS Request for Solutions	February 23, 2012
CMS Capitated Financial Alignment Demonstration application	May 23, 2012
Proposed Model of Care	June 29, 2012
Proposed Medication Management Therapy Program	May 6, 2013
Proposed Part D Formulary	May 31, 2013
Proposed Plan Benefit Package	June 3, 2013
Revised Health Service Delivery Tables for Network Validation	June 26, 2013

Key steps and milestones for the Cal MediConnect program are as follows:

Key Steps and Milestones	Date
Finalize Memorandum of Understanding (MOU) (CMS and DHCS)	Executed March 27, 2013

Key Steps and Milestones	Date
Develop final capitation rates	Ongoing since April 23, 2013
Conduct joint readiness assessments (CMS and DHCS)	Initiated March 2013 and ongoing through December 2013 - Desk Review: April 19, 2013 - On-site visit: July 25-26, 2013 - Remote Systems Testing: October 21, 2013 - Network Validation: October 28, 2013 - Pre-Enrollment Validation: November 20, 2013 - Final Readiness report to be issued mid-December 2013
Execute MOUs with relevant county agencies	Completed in July and August 2013
Sign Three-Way contract	December 13, 2013 (electronic signature) December 16, 2013 (hard copy signature)
Sign CDSS contract for IHSS services	Mid-December 2013 (anticipated)
Finalize Plan Benefit Package in CMS system	Mid-December 2013
Implement Cal MediConnect	No sooner than April 1, 2014

On June 6, 2013, your Board approved CalOptima's FY 2013-14 Operating Budget. Staff clarified that the operating budget did not include infrastructure and implementation funding for the Duals Demonstration (i.e., the Cal MediConnect program), and that Staff would present the budget as a separate Board action.

Discussion

Both DHCS and CMS are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of Cal MediConnect. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted, as noted above, from the prior dates shared with the Board in previous meetings. Staff participated in the on-site readiness review July 25-26, 2013.

The next key step is for CalOptima to sign the Three-Way Agreement with CMS and DHCS. Recently, DHCS notified participating plans that the final date by which CMS will require execution of the Agreement is December 10, 2013. Plans, including CalOptima, received the "final" Three-Way Agreement on November 6, 2013 and were advised that they would not be able to negotiate changes to the Agreement. Although the document contains a number of terms that are currently in other program agreements, this was the first time that plans received the document which contains new Cal MediConnect program requirements, Plans had approximately one week to review the document and submit a list of "significant concerns" to the Agreement. DHCS held a conference call with plans on November 20, 2013 to discuss the comments plans submitted. On the call, the DHCS provided clarification on certain terms, but essentially reiterated that the "final" version was, in fact, final. CMS and DHCS issued interim final rates in late October for plans' thirty (30) day review. Additionally, DHCS has indicated that rates may be subject to additional minor revisions prior to the final execution of the Agreement.

Three-Way Cal MediConnect Agreement

The Agreement between DHCS, CMS, and CalOptima outlines the respective obligations for each party to implement the Cal MediConnect program in Orange County. The Agreement contains provisions for CMS

and DHCS to evaluate CalOptima's performance as a Cal MediConnect participating plan, including adherence to federal Medicare and Medicaid laws.

Below are some areas within the Agreement that will have a significant operational and financial impact:

Requirement / Area of Concern	Impact
Benefits and funding streams	The Agreement reflects continued fragmentation of Medicare and Medi-Cal benefits, services, and funding streams will pose operational challenges. Full integration will likely not occur until year 2 of the demonstration.
Care coordination	The Agreement includes extensive care coordination requirements that conflict with the existing Medicare requirements for a plan's Model of Care are included in the Agreement. Specifically, the ten (10) day timeframe to develop Individualized Care Plans (ICPs) for members after completion of the Health Risk Assessment (HRA) is insufficient.
Rate dispute process	The Agreement excludes rates from the dispute process. Requiring participating plans to waive their legal rights to dispute a rate that may be unreasonable or actuarially unsound is particularly problematic in year 2 and 3 of the demonstration.
Quality withholds	There is a lack of specific information on the quality withhold metrics, and how plans will be measured for purposes of earning back the withheld amount based on performance. The agreement lacks a process for plans to provide meaningful input on the performance metrics that will be tied to the quality withholds for each Demonstration year.
IHSS	Plans are required to assume full risk for IHSS provider payments (i.e., wages and benefits, such as health insurance). The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December. CalOptima Board of Directors would likely have to make a "go / no-go" decision on the 3-way contract for Cal MediConnect in December without the opportunity to review the CDSS contract.
After-hours call capacity	Plans cannot leverage current 24-hour Nurse Advice Lines to meet the after-hours call capacity requirement as the after-hours call service needs to be staffed either by a physician or an appropriate licensed professional under his or her supervision.

Requirement / Area of Concern	Impact
Pending contracts and regulatory guidance	The Agreement incorporates requirements to comply with unissued CMS/DHCS guidance. These references in the Agreement are broad and are not limited to indicating that the guidance will do no more than interpret current requirements under State and Federal laws.
Advisory Committee	Requires the formation of a new Advisory Committee to the Board of Directors, which must consist of not more than eleven (11) people, and no less than fifty percent (50%) of the membership of the advisory committee shall be individuals who are users of personal assistance paid for through public or private funds or recipients of IHSS services.

Other issues related to the Three-Way Agreement for Cal MediConnect include:

- Lack of specific information on IHSS;
  - Data sharing issues with the California Department of Social Services (CDSS) for IHSS; and
  - Contract terms for agreement with CDSS. The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December.

- Reporting requirements not yet specified (e.g., network adequacy, performance measures).

Revisions to CalOptima's FY 2013-14 Implementation, Operating, and Capital Budgets
Staff is submitting revisions to the FY 2013-14 Implementation, Operating, and Capital Budget to the BOD for approval with assumptions based on currently available information.

Proposed Budget 1/1/14 – 6/30/14			
	Implementation	**Operational**	**Total**
Average Monthly Enrollment	N/A	7,118	7,118
Revenue	$0	$43,130,331	$43,130,331
Medical Costs	$2,845,316	$38,414,385	$41,259,701
Administrative Costs	$2,879,267	$4,069,166	$6,948,433
Operating Income/(Loss)	($5,724,583)	$646,780	($5,077,803)
Medical Loss Ratio (MLR)	N/A	89.1%	95.7%
Administrative Loss Ratio (ALR)	N/A	9.4%	16.1%
Capital – Hardware/Software			$1,100,000

Enrollment Assumptions:
- Begins April 1, 2014 with an estimated 3,680 members
- Assumes a pre-enrollment opt-out rate of 20% and disenrollment rate of 5%

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- CY 2014 enrollment will consist of FFS Medicare membership, since Medicare Advantage enrollees are allowed to stay with existing plan through Dec 2014

Revenue Assumptions:
- Bases Medicare rates on draft rates provided in October 2013
- Bases Medi-Cal rates on draft rates provided on November 20, 2013
- Estimates total revenue of $2,019.74 per member per month
- Medicare Part A/B and Part D rates utilizes a base rate and applies a risk adjustment factor (similar to OneCare revenue)
- Medi-Cal rate is a blended rate of four population cohorts: LTC, HCBS High, HCBS Low, and Community Well
- Adjusts rates for savings targets that escalate from 1.4% to 5.5% over the next three and a half years

Medical Cost Assumptions:
- Assumes an average provider capitation rate of 37.5% of Medicare Part A/B premium
- Uses current OneCare medical utilization and unit cost rates as a proxy
- Assumes an MLR of 85.3% on prescription drug benefits
- Assumes an MLR of 90.3% on Medi-Cal wrap-around benefits
- Excludes supplemental benefits with the exception of mental health and transportation services
- Includes program guidelines that require higher levels of Case Management and Health Services
- Estimates eighty-two (82) FTE's are scheduled over the remainder of the year

Administrative Cost Assumptions:
- Includes implementation costs of $5.7 million to prepare the organizations processes, policies, and staff for a targeted go-live date of April 1, 2014
- Program guidelines specify staffing requirements, such as Compliance and Customer Service
- Estimates sixty-three (63) FTE's are scheduled over the remainder of the year
- First twelve (12) months of the program will require higher than standard level of cost for initial items such as member and provider mailings as well as staff recruitment and training. These costs are staged in to occur approximately three (3) months prior to the member enrollment.

Capital Assumptions:
- Includes hardware and software required to support the increase in staffing and projected membership population

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
CCMS (Medical Database)	$ 222,300	20%
Facets Upgrades	204,300	19%
Backup Environment	67,240	6%
Core Infrastructure	58,020	5%
Data Warehouse	43,000	4%

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Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
Misc (Network Costs)	505,140	46%
Total	$ 1,100,000	100%

The Proposed budget includes hardware, software, and professional fees.

Next Steps:
After receipt and review of the Three-Way Agreement and analysis of the interim final rates, Staff recommends the BOD to authorize the Chairman to execute the Three-Way Agreement for CalOptima to participate in Cal MediConnect.

Concurrently, Staff will continue to prepare for the implementation of Cal MediConnect and Managed MLTSS.

Approval of the proposed actions and the Board Chair's execution of the three-way agreement with CMS and DHCS will commit CalOptima to participating in the Cal MediConnect Program.

Fiscal Impact
As outlined above, the proposed revisions to the CalOptima FY 2013-14 Implementation and Operating Budget reflect a deficit of $5.1 million and a Capital Budget of $1.1 million.

Rationale for Recommendation
The DHCS proposal to implement the CCI aligns with CalOptima's long standing commitment to better integrate acute and long term care services. This integration initiative provides CalOptima an opportunity to work with community stakeholders to design a system that fully integrates the administrative and financial responsibilities for Medi-Cal and Medicare covered services and achieve its acute and long term care integration goals.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *11/27/2013*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

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policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

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Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

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Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

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APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

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Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

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- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: January 8, 2019

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer R. Shapiro, Acting Director, Medicare Plan Payment Group

SUBJECT: **Release of 2019 MIPS Payment Adjustment Data File**

The Centers for Medicare & Medicaid Services (CMS) has uploaded to the Health Plan Management System (HPMS) the Merit-based Incentive Payment System (MIPS) Payment Adjustment Data File for payment year 2019. Medicare Advantage organizations (MAOs) can use the information in the file to determine the amount of the MIPS payment adjustment that applies to their payments for Medicare Part B covered professional services furnished by out-of-network MIPS eligible clinicians.

For guidance on when and how the MIPS payments apply to MAOs' payments to MIPS eligible clinicians, please see the April 27, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments" and the November 8, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance."

File Access

The 2019 MIPS Payment Adjustment Data File has been added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). After navigating to the "Incentive Payments" section, a user may download the file by selecting "MIPS Payment Adjustment Data File" under Step One, "2019" under Step Two, and "Download" under Step Three.

Due to the sensitivity of some of the information provided in the file, only the MAO's Medicare Compliance Officer will be able to access and download it. The Compliance Officer must be a registered HPMS user in order to obtain the file.

Identifying the Applicable MIPS Adjustment Percentage

The MIPS Payment Adjustment Data File consists of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)

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- MIPS adjustment percentage
- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see the attached Appendix.

An MAO can identify the applicable MIPS adjustment percentage for a MIPS eligible clinician by matching the clinician's billing TIN/NPI combination to a TIN/NPI combination in the MIPS Payment Adjustment Data File. If an exact match for the billing TIN/NPI combination does not appear in the data file, the MAO should determine whether the NPI appears in combination with another TIN and, if so, apply the MIPS adjustment percentage associated with that TIN/NPI combination. If the NPI appears in more than one TIN/NPI combination in the data file, the MAO should apply the MIPS adjustment percentage for the TIN/NPI combination that results in the greatest total payment amount.

Additional Information

If you encounter technical difficulties when downloading the MIPS Payment Adjustment Data File from HPMS, you may contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028.

If the "Incentive Payments" hyperlink does not appear in the HPMS Data Extract Facility, you must send a request for additional access to hpms_access@cms.hhs.gov. Please note that information in the MIPS Payment Adjustment Data File is considered sensitive and may require additional levels of approval.

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

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Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

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APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

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Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

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policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

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Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

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Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

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APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, except those associated with AltaMed Health Services Corporation, to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

Contact

Michelle Laughlin, Executive Director, Network Operations (714) 246-8400
Nancy Huang, Interim Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the OneCare Connect:

1. Health Network contracts with AMVI Care Health Network, ARTA Western California, Inc., Talbert Medical Group, P.C., Family Choice Medical Group Inc., Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network Inc., Monarch HealthCare, A Medical Group Inc., Orange County Physicians IPA Medical Group Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Prospect Health Plan Inc., and United Care Medical Group, Inc. to:
    i. Extend the OneCare Connect Health Network contract through and including December 31, 2020;
    ii. Add any necessary language provisions required based on the Three-Way Cal MediConnect contract (Three-Way Agreement) between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements, including language reflecting changes related to the Merit-based Incentive Payments System (MIPS) program;
    iii. Clarify access standards for prenatal care; and
2. Physician Hospital Consortium capitated Hospital contract with Fountain Valley Regional Hospital and Medical Center, and OneCare Connect Full-Risk Health Network contracts with Heritage Provider Network Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to incorporate the retrospective non-contracted Ground Emergency Medical Transport (GEMT) provider rate increase requirements for the July 1, 2018 through June 30, 2019 and the July 1, 2019 through June 30, 2020 periods, and the additional compensation to these Health Networks for such services.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (CMC) OneCare Connect beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

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Cal MediConnect was launched in 2014 as a three-year demonstration program implemented across eight counties. OneCare Connect (OCC) was launched July 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated Health Networks to manage services to the network's assigned membership.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019. At its November 2018 meeting, the Board authorized CalOptima to extend the Health Network contracts for one year through December 31, 2019.
At its October 3, 2019 meeting, the Board authorized execution of the newest version of the three-way agreement, which became effective September 1, 2019. Among the key changes of the new agreement was extension of the Cal MediConnect demonstration period through, December 31, 2022, in one-year terms. In accordance with this change, staff is seeking authorization to extend the Health Network agreements for an additional year through December 31, 2020.

Discussion

Language Provisions; Agreement with CMS and DHCS

Contract amendments will be required to include provisions to address technical revisions and any other new/revised requirements from the new Three-Way Agreement that are applicable to the OneCare Connect Health Networks. To be in compliance with the most current version of the Three-Way Agreement received from DHCS, effective September 1, 2019, staff seeks authority to amend OneCare Connect Health Network contracts to ensure contracted OCC Health Networks ensure that providers are enrolled with DHCS as Medicaid providers consistent with all Medicaid enrollment requirements. Other changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Merit-based Incentive Payment Systems (MIPS)

In accordance with the Medicare Access and CHIP Reauthorization Act of 2015 Quality Payment Program memorandum and CalOptima Policies and Procedures, Health Networks implemented the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. This provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Payment to health networks is contingent upon annual receipt of their provider payment adjustment confirmation report, which identifies and reports all claims qualifying for MIPS payment adjustments. Health Networks are required to submit their adjustment reports on an annual basis, starting July 2020. For dates of service January 1, 2019 through December 31, 2019, payment year is 2021. Staff seeks authority to amend contracts to include language in support of the MIPS payment adjustments to the OCC Health Networks to remain in compliance with this CMS-mandated program.

Access Standards for Prenatal Care

As it relates to maternity services and access standards for prenatal care, the OneCare Connect Contract will be updated to be consistent with CalOptima's Medi-Cal Health Network contracts. The Medi-Cal Health Network contract language ensures that the most current standards or guidelines of the American

College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for prenatal services and ensure that Physician Groups have a process in place for follow-up on Member missed appointments.

Ground Emergency Medical Transport (GEMT)

Through the DHCS-established Quality Assurance Fee (QAF) program, retrospective payments to non-contracted Ground Emergency Medical Transport providers have been approved for the State Fiscal Years (SFY) 2018-2019 and 2019-2020, up to $400 per identified service. The program has been designated as a Medi-Cal benefit, requiring CalOptima to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support, Emergency), A0427 (Advanced Life Support, Level 1, Emergency), A0433 (Advanced Life Support, Level 2), A0434 (Specialty Care Transport), and A0225 (Neonatal Emergency Transport). Reimbursement of the difference between the base Medi-Cal rate for eligible services and the increase up to $400 is applicable toward the Physician Hospital Consortia capitated Hospital and Full-Risk Health Network contracts. Payments will be contingent on receipt of the GEMT payment adjustment confirmation report required from the health networks. Reimbursement payments will be made only in cases where the new Medi-Cal rate exceeds the Out-of-Network Medicare allowable reimbursement rate. These amendments will be renewed each year that GEMT provisions are extended past SFY 2019-2020.

Summary of Recommendations

Staff seeks Board authorization to amend the Health Network agreements as needed to extend and add any necessary language provisions required by the Three-Way Agreement, and to include language supporting the provision for MIPS, ACOG and GEMT.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect Health Network capitation expenses of $131 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The recommended action to renew the existing Health Network contracts through June 30, 2020, is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extensions, in the CalOptima FY 2020-21 Operating Budget.

The recommended action to amend the OneCare Connect Physician Hospital Consortium capitated hospital contract and OneCare Connect Full-Risk Health Network contracts to incorporate the retrospective non-contracted GEMT provider rate increase requirements for SFY 2018-19 is budget neutral. Funding for non-contracted GEMT provider payments for OneCare Connect was not included in the CalOptima FY 2019-20 Operating Budget approved by the Board on June 6, 2019. To date, staff has not received the most updated rates from DHCS. However, revenue from the State is anticipated to be sufficient to cover the estimated costs.

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OCC members is maintained, allows flexibility to modify OCC Health Network contracts as needed based on CalOptima's Three-Way Agreement with DHCS and CMS, support CalOptima's payment obligations under the MIPS program, ensure access standards for prenatal care are aligned with the most current ACOG standards and guidelines, and Physician Health Consortium capitated Hospital and Full-Risk Health Network contracts support GEMT payments through the end of Fiscal year 2019-2020.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated December 5, 2013; Consider Participation in the Cal MediConnect Program
3. Board Action dated September 7, 2017; Authorize and Direct Execution of a New Three-Way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program
4. Board Action dated November 1, 2018; Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts
5. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
6. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
7. CMS Release of 2019 MIPS Payment Adjustment Data File
8. Board Action dated September 5, 2019; Consider Actions Related to Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services
9. California State Plan Amendment 19-0020

/s/ Michael Schrader *10/30/2019*

Authorized Signature **Date**

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AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
ARTA Western California, Inc.	1665 Scenic Ave Dr, Suite 100	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
Talbert Medical Group, P.C.	1665 Scenic Avenue, Suite 100	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. C. Consider Participation in the Cal MediConnect Program

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400
Patti McFarland, Chief Financial Officer, (714) 246-8400

Recommended Actions
Consider the following required actions to participate in the Cal MediConnect Program:
1. Authorize and Direct the Chairman of the Board of Directors to Execute the Three-Way Agreement between the California DHCS, CMS and CalOptima for Cal MediConnect, subject to the interim final rates that will not harm the financial viability of CalOptima and reasonable and expected requirements related to operations and reporting;
2. Authorize and Direct the Chairman of the Board of Directors to Execute the California Department of Social Services' (CDSS) Contract for In-Home Supportive Services (IHSS);
3. Approve Revisions Related to Cal MediConnect to CalOptima's Fiscal Year (FY) 2013-14 Budget; and
4. Authorize the CEO to develop and/or update policies necessary to meet Cal MediConnect participation requirements and implement the program's benefit set.

Background
In June 2012, Senate Bill 1008 (2012) and SB 1036 (2012) authorized the Coordinated Care Initiative (CCI). The CCI is composed of two (2) key components that will work in tandem to improve care coordination and integration.

1. Cal MediConnect: No sooner than April 1, 2014, the state will begin a three (3) year federal-state demonstration program in eight (8) counties. Individuals with Medicare and Medi-Cal (i.e., dual eligible beneficiaries) will receive coordinated medical, behavioral health, institutional long-term care, and home and community based services through a single Medi-Cal managed care plan. The participating counties are: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside, and San Bernardino.

2. Managed Medi-Cal Long-Term Supports and Services (MLTSS): No sooner than April 1, 2014, all Medi-Cal beneficiaries, including dual eligible beneficiaries, will receive long-term services and supports and Medi-Cal wrap-around benefits through a Medi-Cal managed care plan. MLTSS includes institutional long-term care, Community Based Adult Services, Multipurpose Senior Services Program, and IHSS.

   As a County Organized Health System (COHS), CalOptima already serves dual eligible beneficiaries, and provides Medi-Cal wrap-around services to members. In addition, pursuant to SB 94 (2013), DHCS separated the MLTSS component from the Cal MediConnect program. Medi-Cal managed care plans will provide MLTSS as a Medi-Cal benefit to all enrollees even if Cal Medi-Connect does not move forward.

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DHCS initially proposed to implement Cal MediConnect no sooner than January 1, 2014. However, DHCS revised the timeline several times to accommodate ongoing negotiations with CMS and to resolve other implementation issues. On August 13, 2013, DHCS formally announced that Cal MediConnect will begin no sooner than April 1, 2014. Initial enrollment will occur on a passive enrollment basis for a twelve (12) month period, based on the eligible beneficiary's birthday month.

CalOptima's FY 2013-14 Operating Budget projected an increased enrollment of 27,000 members from the Cal MediConnect program through June 30, 2014. Staff will make a downward adjustment to the membership projection due to the delayed implementation date, and anticipates approximately 3,700 members will be passively enrolled each month. Staff will implement strategies to minimize the opt-out rate of the Cal MediConnect program.

The Demonstration Years for the Cal MediConnect program are as follows:

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

On May 3, 2012, your Board approved a pre-implementation budget for the CCI of $373,994 to proceed with the application process to participate in the program. The funds were used to support travel and training, consultant fees, limited term staffing, and outreach and engagement. The budget was for the period of May 3, 2012, through August 31, 2012.

On January 3, 2013, your Board approved additional funding to continue pre-implementation planning for the CCI of $615,000 for a total of $988,994. The funds were used to support professional fees and staffing. To date, approximately ninety-five percent (95%) of the pre-implementation funds have been spent. Based on Board approval, staff has completed all state and federal applications and additional requests, including but not limited to:

Key Deliverables	Date
DHCS Request for Solutions	February 23, 2012
CMS Capitated Financial Alignment Demonstration application	May 23, 2012
Proposed Model of Care	June 29, 2012
Proposed Medication Management Therapy Program	May 6, 2013
Proposed Part D Formulary	May 31, 2013
Proposed Plan Benefit Package	June 3, 2013
Revised Health Service Delivery Tables for Network Validation	June 26, 2013

Key steps and milestones for the Cal MediConnect program are as follows:

Key Steps and Milestones	Date
Finalize Memorandum of Understanding (MOU) (CMS and DHCS)	Executed March 27, 2013

Key Steps and Milestones	Date
Develop final capitation rates	Ongoing since April 23, 2013
Conduct joint readiness assessments (CMS and DHCS)	Initiated March 2013 and ongoing through December 2013 - Desk Review: April 19, 2013 - On-site visit: July 25-26, 2013 - Remote Systems Testing: October 21, 2013 - Network Validation: October 28, 2013 - Pre-Enrollment Validation: November 20, 2013 - Final Readiness report to be issued mid-December 2013
Execute MOUs with relevant county agencies	Completed in July and August 2013
Sign Three-Way contract	December 13, 2013 (electronic signature) December 16, 2013 (hard copy signature)
Sign CDSS contract for IHSS services	Mid-December 2013 (anticipated)
Finalize Plan Benefit Package in CMS system	Mid-December 2013
Implement Cal MediConnect	No sooner than April 1, 2014

On June 6, 2013, your Board approved CalOptima's FY 2013-14 Operating Budget. Staff clarified that the operating budget did not include infrastructure and implementation funding for the Duals Demonstration (i.e., the Cal MediConnect program), and that Staff would present the budget as a separate Board action.

Discussion

Both DHCS and CMS are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of Cal MediConnect. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted, as noted above, from the prior dates shared with the Board in previous meetings. Staff participated in the on-site readiness review July 25-26, 2013.

The next key step is for CalOptima to sign the Three-Way Agreement with CMS and DHCS. Recently, DHCS notified participating plans that the final date by which CMS will require execution of the Agreement is December 10, 2013. Plans, including CalOptima, received the "final" Three-Way Agreement on November 6, 2013 and were advised that they would not be able to negotiate changes to the Agreement. Although the document contains a number of terms that are currently in other program agreements, this was the first time that plans received the document which contains new Cal MediConnect program requirements, Plans had approximately one week to review the document and submit a list of "significant concerns" to the Agreement. DHCS held a conference call with plans on November 20, 2013 to discuss the comments plans submitted. On the call, the DHCS provided clarification on certain terms, but essentially reiterated that the "final" version was, in fact, final. CMS and DHCS issued interim final rates in late October for plans' thirty (30) day review. Additionally, DHCS has indicated that rates may be subject to additional minor revisions prior to the final execution of the Agreement.

Three-Way Cal MediConnect Agreement

The Agreement between DHCS, CMS, and CalOptima outlines the respective obligations for each party to implement the Cal MediConnect program in Orange County. The Agreement contains provisions for CMS

and DHCS to evaluate CalOptima's performance as a Cal MediConnect participating plan, including adherence to federal Medicare and Medicaid laws.

Below are some areas within the Agreement that will have a significant operational and financial impact:

Requirement / Area of Concern	Impact
Benefits and funding streams	The Agreement reflects continued fragmentation of Medicare and Medi-Cal benefits, services, and funding streams will pose operational challenges. Full integration will likely not occur until year 2 of the demonstration.
Care coordination	The Agreement includes extensive care coordination requirements that conflict with the existing Medicare requirements for a plan's Model of Care are included in the Agreement. Specifically, the ten (10) day timeframe to develop Individualized Care Plans (ICPs) for members after completion of the Health Risk Assessment (HRA) is insufficient.
Rate dispute process	The Agreement excludes rates from the dispute process. Requiring participating plans to waive their legal rights to dispute a rate that may be unreasonable or actuarially unsound is particularly problematic in year 2 and 3 of the demonstration.
Quality withholds	There is a lack of specific information on the quality withhold metrics, and how plans will be measured for purposes of earning back the withheld amount based on performance. The agreement lacks a process for plans to provide meaningful input on the performance metrics that will be tied to the quality withholds for each Demonstration year.
IHSS	Plans are required to assume full risk for IHSS provider payments (i.e., wages and benefits, such as health insurance). The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December. CalOptima Board of Directors would likely have to make a "go / no-go" decision on the 3-way contract for Cal MediConnect in December without the opportunity to review the CDSS contract.
After-hours call capacity	Plans cannot leverage current 24-hour Nurse Advice Lines to meet the after-hours call capacity requirement as the after-hours call service needs to be staffed either by a physician or an appropriate licensed professional under his or her supervision.

Requirement / Area of Concern	Impact
Pending contracts and regulatory guidance	The Agreement incorporates requirements to comply with unissued CMS/DHCS guidance. These references in the Agreement are broad and are not limited to indicating that the guidance will do no more than interpret current requirements under State and Federal laws.
Advisory Committee	Requires the formation of a new Advisory Committee to the Board of Directors, which must consist of not more than eleven (11) people, and no less than fifty percent (50%) of the membership of the advisory committee shall be individuals who are users of personal assistance paid for through public or private funds or recipients of IHSS services.

Other issues related to the Three-Way Agreement for Cal MediConnect include:

- Lack of specific information on IHSS;
  - Data sharing issues with the California Department of Social Services (CDSS) for IHSS; and
  - Contract terms for agreement with CDSS. The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December.

- Reporting requirements not yet specified (e.g., network adequacy, performance measures).

Revisions to CalOptima's FY 2013-14 Implementation, Operating, and Capital Budgets
Staff is submitting revisions to the FY 2013-14 Implementation, Operating, and Capital Budget to the BOD for approval with assumptions based on currently available information.

Proposed Budget 1/1/14 – 6/30/14			
	Implementation	**Operational**	**Total**
Average Monthly Enrollment	N/A	7,118	7,118
Revenue	$0	$43,130,331	$43,130,331
Medical Costs	$2,845,316	$38,414,385	$41,259,701
Administrative Costs	$2,879,267	$4,069,166	$6,948,433
Operating Income/(Loss)	($5,724,583)	$646,780	($5,077,803)
Medical Loss Ratio (MLR)	N/A	89.1%	95.7%
Administrative Loss Ratio (ALR)	N/A	9.4%	16.1%
Capital – Hardware/Software			$1,100,000

Enrollment Assumptions:
- Begins April 1, 2014 with an estimated 3,680 members
- Assumes a pre-enrollment opt-out rate of 20% and disenrollment rate of 5%

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- CY 2014 enrollment will consist of FFS Medicare membership, since Medicare Advantage enrollees are allowed to stay with existing plan through Dec 2014

Revenue Assumptions:
- Bases Medicare rates on draft rates provided in October 2013
- Bases Medi-Cal rates on draft rates provided on November 20, 2013
- Estimates total revenue of $2,019.74 per member per month
- Medicare Part A/B and Part D rates utilizes a base rate and applies a risk adjustment factor (similar to OneCare revenue)
- Medi-Cal rate is a blended rate of four population cohorts: LTC, HCBS High, HCBS Low, and Community Well
- Adjusts rates for savings targets that escalate from 1.4% to 5.5% over the next three and a half years

Medical Cost Assumptions:
- Assumes an average provider capitation rate of 37.5% of Medicare Part A/B premium
- Uses current OneCare medical utilization and unit cost rates as a proxy
- Assumes an MLR of 85.3% on prescription drug benefits
- Assumes an MLR of 90.3% on Medi-Cal wrap-around benefits
- Excludes supplemental benefits with the exception of mental health and transportation services
- Includes program guidelines that require higher levels of Case Management and Health Services
- Estimates eighty-two (82) FTE's are scheduled over the remainder of the year

Administrative Cost Assumptions:
- Includes implementation costs of $5.7 million to prepare the organizations processes, policies, and staff for a targeted go-live date of April 1, 2014
- Program guidelines specify staffing requirements, such as Compliance and Customer Service
- Estimates sixty-three (63) FTE's are scheduled over the remainder of the year
- First twelve (12) months of the program will require higher than standard level of cost for initial items such as member and provider mailings as well as staff recruitment and training. These costs are staged in to occur approximately three (3) months prior to the member enrollment.

Capital Assumptions:
- Includes hardware and software required to support the increase in staffing and projected membership population

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
CCMS (Medical Database)	$ 222,300	20%
Facets Upgrades	204,300	19%
Backup Environment	67,240	6%
Core Infrastructure	58,020	5%
Data Warehouse	43,000	4%

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Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
Misc (Network Costs)	505,140	46%
Total	$ 1,100,000	100%

The Proposed budget includes hardware, software, and professional fees.

Next Steps:
After receipt and review of the Three-Way Agreement and analysis of the interim final rates, Staff recommends the BOD to authorize the Chairman to execute the Three-Way Agreement for CalOptima to participate in Cal MediConnect.

Concurrently, Staff will continue to prepare for the implementation of Cal MediConnect and Managed MLTSS.

Approval of the proposed actions and the Board Chair's execution of the three-way agreement with CMS and DHCS will commit CalOptima to participating in the Cal MediConnect Program.

Fiscal Impact
As outlined above, the proposed revisions to the CalOptima FY 2013-14 Implementation and Operating Budget reflect a deficit of $5.1 million and a Capital Budget of $1.1 million.

Rationale for Recommendation
The DHCS proposal to implement the CCI aligns with CalOptima's long standing commitment to better integrate acute and long term care services. This integration initiative provides CalOptima an opportunity to work with community stakeholders to design a system that fully integrates the administrative and financial responsibilities for Medi-Cal and Medicare covered services and achieve its acute and long term care integration goals.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *11/27/2013*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

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policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

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Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

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Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

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APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

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Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

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- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: January 8, 2019

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer R. Shapiro, Acting Director, Medicare Plan Payment Group

SUBJECT: **Release of 2019 MIPS Payment Adjustment Data File**

The Centers for Medicare & Medicaid Services (CMS) has uploaded to the Health Plan Management System (HPMS) the Merit-based Incentive Payment System (MIPS) Payment Adjustment Data File for payment year 2019. Medicare Advantage organizations (MAOs) can use the information in the file to determine the amount of the MIPS payment adjustment that applies to their payments for Medicare Part B covered professional services furnished by out-of-network MIPS eligible clinicians.

For guidance on when and how the MIPS payments apply to MAOs' payments to MIPS eligible clinicians, please see the April 27, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments" and the November 8, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance."

File Access

The 2019 MIPS Payment Adjustment Data File has been added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). After navigating to the "Incentive Payments" section, a user may download the file by selecting "MIPS Payment Adjustment Data File" under Step One, "2019" under Step Two, and "Download" under Step Three.

Due to the sensitivity of some of the information provided in the file, only the MAO's Medicare Compliance Officer will be able to access and download it. The Compliance Officer must be a registered HPMS user in order to obtain the file.

Identifying the Applicable MIPS Adjustment Percentage

The MIPS Payment Adjustment Data File consists of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)

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- MIPS adjustment percentage
- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see the attached Appendix.

An MAO can identify the applicable MIPS adjustment percentage for a MIPS eligible clinician by matching the clinician's billing TIN/NPI combination to a TIN/NPI combination in the MIPS Payment Adjustment Data File. If an exact match for the billing TIN/NPI combination does not appear in the data file, the MAO should determine whether the NPI appears in combination with another TIN and, if so, apply the MIPS adjustment percentage associated with that TIN/NPI combination. If the NPI appears in more than one TIN/NPI combination in the data file, the MAO should apply the MIPS adjustment percentage for the TIN/NPI combination that results in the greatest total payment amount.

Additional Information

If you encounter technical difficulties when downloading the MIPS Payment Adjustment Data File from HPMS, you may contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028.

If the "Incentive Payments" hyperlink does not appear in the HPMS Data Extract Facility, you must send a request for additional access to hpms_access@cms.hhs.gov. Please note that information in the MIPS Payment Adjustment Data File is considered sensitive and may require additional levels of approval.

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

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increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

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Attachment to the September 5, 2019 Board of Directors Meeting – Agenda Item 9

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Regional Operations Group

September 6, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 19-0020, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 30, 2019. SPA 19-0020 continues the Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers to Medi-Cal patients from July 1, 2019 to June 30, 2020.

The effective date of this SPA is July 1, 2019. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard C. Allen
Director
Western Regional Operations Group

cc: Jacey Cooper, California Department of Health Care Services (DHCS)
Lindy Harrington, DHCS
Connie Florez, DHCS
Michelle Tamai, DHCS
Adam Neighbours, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 19 — 00 20

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: Title 42 CFR 447 Subpart F

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ 2019 $ $4,809,054
b. FFY ~~2019~~ 2020 $ $14,427,163

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 29, Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Supplement 29, Attachment 4.19-B, pages 1-2

10. SUBJECT OF AMENDMENT

One-year reimbursement rate add-on for ground emergency medical transports with dates of service between July 1, 2019 and June 30, 2020.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME: Mari Cantwell

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: July 30, 2019

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: July 30, 2019

18. DATE APPROVED: September 6, 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME: Richard C. Allen

22. TITLE: Director, Center for Medicaid & CHIP Services, Regional Operations Group

23. REMARKS

For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.

Box 7: CMS pen and ink change to update years per state response to informal questions dated 8/21/19.

FORM CMS-179 (07/92)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, as described below, effective July 1, 2018 through June 30, 2019 and July 1, 2019 through June 30, 2020. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429 BLS Emergency, A0427 ALS Emergency, A0433 ALS2, A0434 Specialty Care Transport, and A0225 Neonatal Emergency Transport. An "emergency medical transport" does not occur when, following evaluation of a patient, a transport is not provided.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for SFY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 is $339.00. The add-on is paid on a per-claim basis.

For SFY 2019-20, the reimbursement rate add-on is fixed. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, A0433, and A0434 is $339.00, and for CPT Code A0225 is $400.72. The add-on is paid for each eligible CPT Code on a per-claim basis.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

Service Code	Description	Current Payment*	Add On Amount	Resulting Total Payment
A0429	Basic Life Support, Emergency	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00
A0434	Specialty Care Transport	$118.20	$220.80	$339.00
A0225	Neonatal Emergency Transport	$179.92	$220.80	$400.72

*These are the base rates associated with these codes, but are subject to further adjustments pursuant to the State Plan.

The resulting total payment amount as listed in the table above for the applicable CPT Code is considered the Rogers rate, which managed care organizations shall pay noncontract managed care emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code, for each state fiscal year the FFS reimbursement rate add-on is effective.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, except those associated with AltaMed Health Services Corporation, to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

Contact

Michelle Laughlin, Executive Director, Network Operations (714) 246-8400
Nancy Huang, Interim Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the OneCare Connect:

1. Health Network contracts with AMVI Care Health Network, ARTA Western California, Inc., Talbert Medical Group, P.C., Family Choice Medical Group Inc., Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network Inc., Monarch HealthCare, A Medical Group Inc., Orange County Physicians IPA Medical Group Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Prospect Health Plan Inc., and United Care Medical Group, Inc. to:
    i. Extend the OneCare Connect Health Network contract through and including December 31, 2020;
    ii. Add any necessary language provisions required based on the Three-Way Cal MediConnect contract (Three-Way Agreement) between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements, including language reflecting changes related to the Merit-based Incentive Payments System (MIPS) program;
    iii. Clarify access standards for prenatal care; and
2. Physician Hospital Consortium capitated Hospital contract with Fountain Valley Regional Hospital and Medical Center, and OneCare Connect Full-Risk Health Network contracts with Heritage Provider Network Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to incorporate the retrospective non-contracted Ground Emergency Medical Transport (GEMT) provider rate increase requirements for the July 1, 2018 through June 30, 2019 and the July 1, 2019 through June 30, 2020 periods, and the additional compensation to these Health Networks for such services.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (CMC) OneCare Connect beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

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Cal MediConnect was launched in 2014 as a three-year demonstration program implemented across eight counties. OneCare Connect (OCC) was launched July 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated Health Networks to manage services to the network's assigned membership.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019. At its November 2018 meeting, the Board authorized CalOptima to extend the Health Network contracts for one year through December 31, 2019.
At its October 3, 2019 meeting, the Board authorized execution of the newest version of the three-way agreement, which became effective September 1, 2019. Among the key changes of the new agreement was extension of the Cal MediConnect demonstration period through, December 31, 2022, in one-year terms. In accordance with this change, staff is seeking authorization to extend the Health Network agreements for an additional year through December 31, 2020.

Discussion

Language Provisions; Agreement with CMS and DHCS

Contract amendments will be required to include provisions to address technical revisions and any other new/revised requirements from the new Three-Way Agreement that are applicable to the OneCare Connect Health Networks. To be in compliance with the most current version of the Three-Way Agreement received from DHCS, effective September 1, 2019, staff seeks authority to amend OneCare Connect Health Network contracts to ensure contracted OCC Health Networks ensure that providers are enrolled with DHCS as Medicaid providers consistent with all Medicaid enrollment requirements. Other changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Merit-based Incentive Payment Systems (MIPS)

In accordance with the Medicare Access and CHIP Reauthorization Act of 2015 Quality Payment Program memorandum and CalOptima Policies and Procedures, Health Networks implemented the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. This provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Payment to health networks is contingent upon annual receipt of their provider payment adjustment confirmation report, which identifies and reports all claims qualifying for MIPS payment adjustments. Health Networks are required to submit their adjustment reports on an annual basis, starting July 2020. For dates of service January 1, 2019 through December 31, 2019, payment year is 2021. Staff seeks authority to amend contracts to include language in support of the MIPS payment adjustments to the OCC Health Networks to remain in compliance with this CMS-mandated program.

Access Standards for Prenatal Care

As it relates to maternity services and access standards for prenatal care, the OneCare Connect Contract will be updated to be consistent with CalOptima's Medi-Cal Health Network contracts. The Medi-Cal Health Network contract language ensures that the most current standards or guidelines of the American

College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for prenatal services and ensure that Physician Groups have a process in place for follow-up on Member missed appointments.

Ground Emergency Medical Transport (GEMT)

Through the DHCS-established Quality Assurance Fee (QAF) program, retrospective payments to non-contracted Ground Emergency Medical Transport providers have been approved for the State Fiscal Years (SFY) 2018-2019 and 2019-2020, up to $400 per identified service. The program has been designated as a Medi-Cal benefit, requiring CalOptima to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support, Emergency), A0427 (Advanced Life Support, Level 1, Emergency), A0433 (Advanced Life Support, Level 2), A0434 (Specialty Care Transport), and A0225 (Neonatal Emergency Transport). Reimbursement of the difference between the base Medi-Cal rate for eligible services and the increase up to $400 is applicable toward the Physician Hospital Consortia capitated Hospital and Full-Risk Health Network contracts. Payments will be contingent on receipt of the GEMT payment adjustment confirmation report required from the health networks. Reimbursement payments will be made only in cases where the new Medi-Cal rate exceeds the Out-of-Network Medicare allowable reimbursement rate. These amendments will be renewed each year that GEMT provisions are extended past SFY 2019-2020.

Summary of Recommendations

Staff seeks Board authorization to amend the Health Network agreements as needed to extend and add any necessary language provisions required by the Three-Way Agreement, and to include language supporting the provision for MIPS, ACOG and GEMT.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect Health Network capitation expenses of $131 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The recommended action to renew the existing Health Network contracts through June 30, 2020, is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extensions, in the CalOptima FY 2020-21 Operating Budget.

The recommended action to amend the OneCare Connect Physician Hospital Consortium capitated hospital contract and OneCare Connect Full-Risk Health Network contracts to incorporate the retrospective non-contracted GEMT provider rate increase requirements for SFY 2018-19 is budget neutral. Funding for non-contracted GEMT provider payments for OneCare Connect was not included in the CalOptima FY 2019-20 Operating Budget approved by the Board on June 6, 2019. To date, staff has not received the most updated rates from DHCS. However, revenue from the State is anticipated to be sufficient to cover the estimated costs.

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OCC members is maintained, allows flexibility to modify OCC Health Network contracts as needed based on CalOptima's Three-Way Agreement with DHCS and CMS, support CalOptima's payment obligations under the MIPS program, ensure access standards for prenatal care are aligned with the most current ACOG standards and guidelines, and Physician Health Consortium capitated Hospital and Full-Risk Health Network contracts support GEMT payments through the end of Fiscal year 2019-2020.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated December 5, 2013; Consider Participation in the Cal MediConnect Program
3. Board Action dated September 7, 2017; Authorize and Direct Execution of a New Three-Way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program
4. Board Action dated November 1, 2018; Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts
5. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
6. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
7. CMS Release of 2019 MIPS Payment Adjustment Data File
8. Board Action dated September 5, 2019; Consider Actions Related to Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services
9. California State Plan Amendment 19-0020

/s/ Michael Schrader *10/30/2019*

Authorized Signature **Date**

AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
ARTA Western California, Inc.	1665 Scenic Ave Dr, Suite 100	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
Talbert Medical Group, P.C.	1665 Scenic Avenue, Suite 100	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. C. Consider Participation in the Cal MediConnect Program

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400
Patti McFarland, Chief Financial Officer, (714) 246-8400

Recommended Actions
Consider the following required actions to participate in the Cal MediConnect Program:
1. Authorize and Direct the Chairman of the Board of Directors to Execute the Three-Way Agreement between the California DHCS, CMS and CalOptima for Cal MediConnect, subject to the interim final rates that will not harm the financial viability of CalOptima and reasonable and expected requirements related to operations and reporting;
2. Authorize and Direct the Chairman of the Board of Directors to Execute the California Department of Social Services' (CDSS) Contract for In-Home Supportive Services (IHSS);
3. Approve Revisions Related to Cal MediConnect to CalOptima's Fiscal Year (FY) 2013-14 Budget; and
4. Authorize the CEO to develop and/or update policies necessary to meet Cal MediConnect participation requirements and implement the program's benefit set.

Background
In June 2012, Senate Bill 1008 (2012) and SB 1036 (2012) authorized the Coordinated Care Initiative (CCI). The CCI is composed of two (2) key components that will work in tandem to improve care coordination and integration.

1. Cal MediConnect: No sooner than April 1, 2014, the state will begin a three (3) year federal-state demonstration program in eight (8) counties. Individuals with Medicare and Medi-Cal (i.e., dual eligible beneficiaries) will receive coordinated medical, behavioral health, institutional long-term care, and home and community based services through a single Medi-Cal managed care plan. The participating counties are: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside, and San Bernardino.

2. Managed Medi-Cal Long-Term Supports and Services (MLTSS): No sooner than April 1, 2014, all Medi-Cal beneficiaries, including dual eligible beneficiaries, will receive long-term services and supports and Medi-Cal wrap-around benefits through a Medi-Cal managed care plan. MLTSS includes institutional long-term care, Community Based Adult Services, Multipurpose Senior Services Program, and IHSS.

   As a County Organized Health System (COHS), CalOptima already serves dual eligible beneficiaries, and provides Medi-Cal wrap-around services to members. In addition, pursuant to SB 94 (2013), DHCS separated the MLTSS component from the Cal MediConnect program. Medi-Cal managed care plans will provide MLTSS as a Medi-Cal benefit to all enrollees even if Cal Medi-Connect does not move forward.

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DHCS initially proposed to implement Cal MediConnect no sooner than January 1, 2014. However, DHCS revised the timeline several times to accommodate ongoing negotiations with CMS and to resolve other implementation issues. On August 13, 2013, DHCS formally announced that Cal MediConnect will begin no sooner than April 1, 2014. Initial enrollment will occur on a passive enrollment basis for a twelve (12) month period, based on the eligible beneficiary's birthday month.

CalOptima's FY 2013-14 Operating Budget projected an increased enrollment of 27,000 members from the Cal MediConnect program through June 30, 2014. Staff will make a downward adjustment to the membership projection due to the delayed implementation date, and anticipates approximately 3,700 members will be passively enrolled each month. Staff will implement strategies to minimize the opt-out rate of the Cal MediConnect program.

The Demonstration Years for the Cal MediConnect program are as follows:

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

On May 3, 2012, your Board approved a pre-implementation budget for the CCI of $373,994 to proceed with the application process to participate in the program. The funds were used to support travel and training, consultant fees, limited term staffing, and outreach and engagement. The budget was for the period of May 3, 2012, through August 31, 2012.

On January 3, 2013, your Board approved additional funding to continue pre-implementation planning for the CCI of $615,000 for a total of $988,994. The funds were used to support professional fees and staffing. To date, approximately ninety-five percent (95%) of the pre-implementation funds have been spent. Based on Board approval, staff has completed all state and federal applications and additional requests, including but not limited to:

Key Deliverables	Date
DHCS Request for Solutions	February 23, 2012
CMS Capitated Financial Alignment Demonstration application	May 23, 2012
Proposed Model of Care	June 29, 2012
Proposed Medication Management Therapy Program	May 6, 2013
Proposed Part D Formulary	May 31, 2013
Proposed Plan Benefit Package	June 3, 2013
Revised Health Service Delivery Tables for Network Validation	June 26, 2013

Key steps and milestones for the Cal MediConnect program are as follows:

Key Steps and Milestones	Date
Finalize Memorandum of Understanding (MOU) (CMS and DHCS)	Executed March 27, 2013

Key Steps and Milestones	Date
Develop final capitation rates	Ongoing since April 23, 2013
Conduct joint readiness assessments (CMS and DHCS)	Initiated March 2013 and ongoing through December 2013 - Desk Review: April 19, 2013 - On-site visit: July 25-26, 2013 - Remote Systems Testing: October 21, 2013 - Network Validation: October 28, 2013 - Pre-Enrollment Validation: November 20, 2013 - Final Readiness report to be issued mid-December 2013
Execute MOUs with relevant county agencies	Completed in July and August 2013
Sign Three-Way contract	December 13, 2013 (electronic signature) December 16, 2013 (hard copy signature)
Sign CDSS contract for IHSS services	Mid-December 2013 (anticipated)
Finalize Plan Benefit Package in CMS system	Mid-December 2013
Implement Cal MediConnect	No sooner than April 1, 2014

On June 6, 2013, your Board approved CalOptima's FY 2013-14 Operating Budget. Staff clarified that the operating budget did not include infrastructure and implementation funding for the Duals Demonstration (i.e., the Cal MediConnect program), and that Staff would present the budget as a separate Board action.

Discussion

Both DHCS and CMS are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of Cal MediConnect. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted, as noted above, from the prior dates shared with the Board in previous meetings. Staff participated in the on-site readiness review July 25-26, 2013.

The next key step is for CalOptima to sign the Three-Way Agreement with CMS and DHCS. Recently, DHCS notified participating plans that the final date by which CMS will require execution of the Agreement is December 10, 2013. Plans, including CalOptima, received the "final" Three-Way Agreement on November 6, 2013 and were advised that they would not be able to negotiate changes to the Agreement. Although the document contains a number of terms that are currently in other program agreements, this was the first time that plans received the document which contains new Cal MediConnect program requirements, Plans had approximately one week to review the document and submit a list of "significant concerns" to the Agreement. DHCS held a conference call with plans on November 20, 2013 to discuss the comments plans submitted. On the call, the DHCS provided clarification on certain terms, but essentially reiterated that the "final" version was, in fact, final. CMS and DHCS issued interim final rates in late October for plans' thirty (30) day review. Additionally, DHCS has indicated that rates may be subject to additional minor revisions prior to the final execution of the Agreement.

Three-Way Cal MediConnect Agreement

The Agreement between DHCS, CMS, and CalOptima outlines the respective obligations for each party to implement the Cal MediConnect program in Orange County. The Agreement contains provisions for CMS

and DHCS to evaluate CalOptima's performance as a Cal MediConnect participating plan, including adherence to federal Medicare and Medicaid laws.

Below are some areas within the Agreement that will have a significant operational and financial impact:

Requirement / Area of Concern	Impact
Benefits and funding streams	The Agreement reflects continued fragmentation of Medicare and Medi-Cal benefits, services, and funding streams will pose operational challenges. Full integration will likely not occur until year 2 of the demonstration.
Care coordination	The Agreement includes extensive care coordination requirements that conflict with the existing Medicare requirements for a plan's Model of Care are included in the Agreement. Specifically, the ten (10) day timeframe to develop Individualized Care Plans (ICPs) for members after completion of the Health Risk Assessment (HRA) is insufficient.
Rate dispute process	The Agreement excludes rates from the dispute process. Requiring participating plans to waive their legal rights to dispute a rate that may be unreasonable or actuarially unsound is particularly problematic in year 2 and 3 of the demonstration.
Quality withholds	There is a lack of specific information on the quality withhold metrics, and how plans will be measured for purposes of earning back the withheld amount based on performance. The agreement lacks a process for plans to provide meaningful input on the performance metrics that will be tied to the quality withholds for each Demonstration year.
IHSS	Plans are required to assume full risk for IHSS provider payments (i.e., wages and benefits, such as health insurance). The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December. CalOptima Board of Directors would likely have to make a "go / no-go" decision on the 3-way contract for Cal MediConnect in December without the opportunity to review the CDSS contract.
After-hours call capacity	Plans cannot leverage current 24-hour Nurse Advice Lines to meet the after-hours call capacity requirement as the after-hours call service needs to be staffed either by a physician or an appropriate licensed professional under his or her supervision.

Requirement / Area of Concern	Impact
Pending contracts and regulatory guidance	The Agreement incorporates requirements to comply with unissued CMS/DHCS guidance. These references in the Agreement are broad and are not limited to indicating that the guidance will do no more than interpret current requirements under State and Federal laws.
Advisory Committee	Requires the formation of a new Advisory Committee to the Board of Directors, which must consist of not more than eleven (11) people, and no less than fifty percent (50%) of the membership of the advisory committee shall be individuals who are users of personal assistance paid for through public or private funds or recipients of IHSS services.

Other issues related to the Three-Way Agreement for Cal MediConnect include:

- Lack of specific information on IHSS;
  - Data sharing issues with the California Department of Social Services (CDSS) for IHSS; and
  - Contract terms for agreement with CDSS. The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December.

- Reporting requirements not yet specified (e.g., network adequacy, performance measures).

Revisions to CalOptima's FY 2013-14 Implementation, Operating, and Capital Budgets
Staff is submitting revisions to the FY 2013-14 Implementation, Operating, and Capital Budget to the BOD for approval with assumptions based on currently available information.

Proposed Budget 1/1/14 – 6/30/14			
	Implementation	**Operational**	**Total**
Average Monthly Enrollment	N/A	7,118	7,118
Revenue	$0	$43,130,331	$43,130,331
Medical Costs	$2,845,316	$38,414,385	$41,259,701
Administrative Costs	$2,879,267	$4,069,166	$6,948,433
Operating Income/(Loss)	($5,724,583)	$646,780	($5,077,803)
Medical Loss Ratio (MLR)	N/A	89.1%	95.7%
Administrative Loss Ratio (ALR)	N/A	9.4%	16.1%
Capital – Hardware/Software			$1,100,000

Enrollment Assumptions:
- Begins April 1, 2014 with an estimated 3,680 members
- Assumes a pre-enrollment opt-out rate of 20% and disenrollment rate of 5%

- CY 2014 enrollment will consist of FFS Medicare membership, since Medicare Advantage enrollees are allowed to stay with existing plan through Dec 2014

Revenue Assumptions:
- Bases Medicare rates on draft rates provided in October 2013
- Bases Medi-Cal rates on draft rates provided on November 20, 2013
- Estimates total revenue of $2,019.74 per member per month
- Medicare Part A/B and Part D rates utilizes a base rate and applies a risk adjustment factor (similar to OneCare revenue)
- Medi-Cal rate is a blended rate of four population cohorts: LTC, HCBS High, HCBS Low, and Community Well
- Adjusts rates for savings targets that escalate from 1.4% to 5.5% over the next three and a half years

Medical Cost Assumptions:
- Assumes an average provider capitation rate of 37.5% of Medicare Part A/B premium
- Uses current OneCare medical utilization and unit cost rates as a proxy
- Assumes an MLR of 85.3% on prescription drug benefits
- Assumes an MLR of 90.3% on Medi-Cal wrap-around benefits
- Excludes supplemental benefits with the exception of mental health and transportation services
- Includes program guidelines that require higher levels of Case Management and Health Services
- Estimates eighty-two (82) FTE's are scheduled over the remainder of the year

Administrative Cost Assumptions:
- Includes implementation costs of $5.7 million to prepare the organizations processes, policies, and staff for a targeted go-live date of April 1, 2014
- Program guidelines specify staffing requirements, such as Compliance and Customer Service
- Estimates sixty-three (63) FTE's are scheduled over the remainder of the year
- First twelve (12) months of the program will require higher than standard level of cost for initial items such as member and provider mailings as well as staff recruitment and training. These costs are staged in to occur approximately three (3) months prior to the member enrollment.

Capital Assumptions:
- Includes hardware and software required to support the increase in staffing and projected membership population

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
CCMS (Medical Database)	$ 222,300	20%
Facets Upgrades	204,300	19%
Backup Environment	67,240	6%
Core Infrastructure	58,020	5%
Data Warehouse	43,000	4%

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
Misc (Network Costs)	505,140	46%
Total	$ 1,100,000	100%

The Proposed budget includes hardware, software, and professional fees.

Next Steps:
After receipt and review of the Three-Way Agreement and analysis of the interim final rates, Staff recommends the BOD to authorize the Chairman to execute the Three-Way Agreement for CalOptima to participate in Cal MediConnect.

Concurrently, Staff will continue to prepare for the implementation of Cal MediConnect and Managed MLTSS.

Approval of the proposed actions and the Board Chair's execution of the three-way agreement with CMS and DHCS will commit CalOptima to participating in the Cal MediConnect Program.

Fiscal Impact
As outlined above, the proposed revisions to the CalOptima FY 2013-14 Implementation and Operating Budget reflect a deficit of $5.1 million and a Capital Budget of $1.1 million.

Rationale for Recommendation
The DHCS proposal to implement the CCI aligns with CalOptima's long standing commitment to better integrate acute and long term care services. This integration initiative provides CalOptima an opportunity to work with community stakeholders to design a system that fully integrates the administrative and financial responsibilities for Medi-Cal and Medicare covered services and achieve its acute and long term care integration goals.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/27/2013*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

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- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: January 8, 2019

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer R. Shapiro, Acting Director, Medicare Plan Payment Group

SUBJECT: **Release of 2019 MIPS Payment Adjustment Data File**

The Centers for Medicare & Medicaid Services (CMS) has uploaded to the Health Plan Management System (HPMS) the Merit-based Incentive Payment System (MIPS) Payment Adjustment Data File for payment year 2019. Medicare Advantage organizations (MAOs) can use the information in the file to determine the amount of the MIPS payment adjustment that applies to their payments for Medicare Part B covered professional services furnished by out-of-network MIPS eligible clinicians.

For guidance on when and how the MIPS payments apply to MAOs' payments to MIPS eligible clinicians, please see the April 27, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments" and the November 8, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance."

File Access

The 2019 MIPS Payment Adjustment Data File has been added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). After navigating to the "Incentive Payments" section, a user may download the file by selecting "MIPS Payment Adjustment Data File" under Step One, "2019" under Step Two, and "Download" under Step Three.

Due to the sensitivity of some of the information provided in the file, only the MAO's Medicare Compliance Officer will be able to access and download it. The Compliance Officer must be a registered HPMS user in order to obtain the file.

Identifying the Applicable MIPS Adjustment Percentage

The MIPS Payment Adjustment Data File consists of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)

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- MIPS adjustment percentage
- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see the attached Appendix.

An MAO can identify the applicable MIPS adjustment percentage for a MIPS eligible clinician by matching the clinician's billing TIN/NPI combination to a TIN/NPI combination in the MIPS Payment Adjustment Data File. If an exact match for the billing TIN/NPI combination does not appear in the data file, the MAO should determine whether the NPI appears in combination with another TIN and, if so, apply the MIPS adjustment percentage associated with that TIN/NPI combination. If the NPI appears in more than one TIN/NPI combination in the data file, the MAO should apply the MIPS adjustment percentage for the TIN/NPI combination that results in the greatest total payment amount.

Additional Information

If you encounter technical difficulties when downloading the MIPS Payment Adjustment Data File from HPMS, you may contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028.

If the "Incentive Payments" hyperlink does not appear in the HPMS Data Extract Facility, you must send a request for additional access to hpms_access@cms.hhs.gov. Please note that information in the MIPS Payment Adjustment Data File is considered sensitive and may require additional levels of approval.

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

Appendix

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

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increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

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Attachment to the September 5, 2019 Board of Directors Meeting – Agenda Item 9

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Regional Operations Group

September 6, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 19-0020, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 30, 2019. SPA 19-0020 continues the Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers to Medi-Cal patients from July 1, 2019 to June 30, 2020.

The effective date of this SPA is July 1, 2019. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard C. Allen
Director
Western Regional Operations Group

cc: Jacey Cooper, California Department of Health Care Services (DHCS)
Lindy Harrington, DHCS
Connie Florez, DHCS
Michelle Tamai, DHCS
Adam Neighbours, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 19 — 00 20

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: Title 42 CFR 447 Subpart F

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ 2019 $ $4,809,054
b. FFY ~~2019~~ 2020 $ $14,427,163

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 29, Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Supplement 29, Attachment 4.19-B, pages 1-2

10. SUBJECT OF AMENDMENT

One-year reimbursement rate add-on for ground emergency medical transports with dates of service between July 1, 2019 and June 30, 2020.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Mari Cantwell

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: July 30, 2019

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: July 30, 2019

18. DATE APPROVED: September 6, 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Richard C. Allen

22. TITLE: Director, Center for Medicaid & CHIP Services, Regional Operations Group

23. REMARKS

For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.

Box 7: CMS pen and ink change to update years per state response to informal questions dated 8/21/19.

FORM CMS-179 (07/92)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, as described below, effective July 1, 2018 through June 30, 2019 and July 1, 2019 through June 30, 2020. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429 BLS Emergency, A0427 ALS Emergency, A0433 ALS2, A0434 Specialty Care Transport, and A0225 Neonatal Emergency Transport. An "emergency medical transport" does not occur when, following evaluation of a patient, a transport is not provided.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for SFY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 is $339.00. The add-on is paid on a per-claim basis.

For SFY 2019-20, the reimbursement rate add-on is fixed. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, A0433, and A0434 is $339.00, and for CPT Code A0225 is $400.72. The add-on is paid for each eligible CPT Code on a per-claim basis.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

Service Code	Description	Current Payment*	Add On Amount	Resulting Total Payment
A0429	Basic Life Support, Emergency	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00
A0434	Specialty Care Transport	$118.20	$220.80	$339.00
A0225	Neonatal Emergency Transport	$179.92	$220.80	$400.72

*These are the base rates associated with these codes, but are subject to further adjustments pursuant to the State Plan.

The resulting total payment amount as listed in the table above for the applicable CPT Code is considered the Rogers rate, which managed care organizations shall pay noncontract managed care emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code, for each state fiscal year the FFS reimbursement rate add-on is effective.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

Contact

Michelle Laughlin, Executive Director, Network Operations (714) 246-8400
Nancy Huang, Interim Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the OneCare Connect Health Network contracts with AltaMed Health Services Corporation to:

i. Extend the OneCare Connect Health Network contract through and including December 31, 2020;
ii. Add any necessary language provisions required based on the Three-Way Cal MediConnect contract (Three-Way Agreement) between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements, including language reflecting changes related to the Merit-based Incentive Payments System (MIPS) program; and
iii. Clarify access standards for prenatal care.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (CMC) OneCare Connect beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

Cal MediConnect was launched in 2014 as a three-year demonstration program implemented across eight counties. OneCare Connect (OCC) was launched July 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated Health Networks to manage services to the network's assigned membership.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019. At its November 2018 meeting, the Board authorized CalOptima to extend the Health Network contracts for one year through December 31, 2019.
At its October 3, 2019 meeting, the Board authorized execution of the newest version of the three-way agreement, which became effective September 1, 2019. Among the key changes of the new agreement was extension of the Cal MediConnect demonstration period through, December 31, 2022, in one-year

terms. In accordance with this change, staff is seeking authorization to extend the Health Network agreements for an additional year through December 31, 2020.

Discussion

Language Provisions; Agreement with CMS and DHCS

Contract amendments will be required to include provisions to address technical revisions and any other new/revised requirements from the new Three-Way Agreement that are applicable to the OneCare Connect Health Networks. To be in compliance with the most current version of the Three-Way Agreement received from DHCS, effective September 1, 2019, staff seeks authority to amend OneCare Connect Health Network contracts to ensure contracted OCC Health Networks ensure that providers are enrolled with DHCS as Medicaid providers consistent with all Medicaid enrollment requirements. Other changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Merit-based Incentive Payment Systems (MIPS)

In accordance with the Medicare Access and CHIP Reauthorization Act of 2015 Quality Payment Program memorandum and CalOptima Policies and Procedures, Health Networks implemented the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. This provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Payment to health networks is contingent upon annual receipt of their provider payment adjustment confirmation report, which identifies and reports all claims qualifying for MIPS payment adjustments. Health Networks are required to submit their adjustment reports on an annual basis, starting July 2020. For dates of service January 1, 2019 through December 31, 2019, payment year is 2021. Staff seeks authority to amend contracts to include language in support of the MIPS payment adjustments to the OCC Health Networks to remain in compliance with this CMS-mandated program.

Access Standards for Prenatal Care

As it relates to maternity services and access standards for prenatal care, the OneCare Connect Contract will be updated to be consistent with CalOptima's Medi-Cal Health Network contracts. The Medi-Cal Health Network contract language ensures that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for prenatal services and ensure that Physician Groups have a process in place for follow-up on Member missed appointments.

Summary of Recommendations

Staff seeks Board authorization to amend the Health Network agreements as needed to extend and add any necessary language provisions required by the Three-Way Agreement, and to include language supporting the provision for MIPS, ACOG and GEMT.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect Health Network capitation expenses of $131 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The

recommended action to renew the existing Health Network contracts through June 30, 2020 is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extensions, in the CalOptima FY 2020-21 Operating Budget.

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OCC members is maintained, allows flexibility to modify OCC Health Network contracts as needed based on CalOptima's Three-Way Agreement with DHCS and CMS, support CalOptima's payment obligations under the MIPS program, and ensure access standards for prenatal care are aligned with the most current ACOG standards and guidelines.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated December 5, 2013; Consider Participation in the Cal MediConnect Program
3. Board Action dated September 7, 2017; Authorize and Direct Execution of a New Three-Way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program
4. Board Action dated November 1, 2018; Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts
5. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
6. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
7. CMS Release of 2019 MIPS Payment Adjustment Data File

/s/ Michael Schrader — *10/30/2019*

Authorized Signature — **Date**

AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. C. Consider Participation in the Cal MediConnect Program

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400
Patti McFarland, Chief Financial Officer, (714) 246-8400

Recommended Actions
Consider the following required actions to participate in the Cal MediConnect Program:
1. Authorize and Direct the Chairman of the Board of Directors to Execute the Three-Way Agreement between the California DHCS, CMS and CalOptima for Cal MediConnect, subject to the interim final rates that will not harm the financial viability of CalOptima and reasonable and expected requirements related to operations and reporting;
2. Authorize and Direct the Chairman of the Board of Directors to Execute the California Department of Social Services' (CDSS) Contract for In-Home Supportive Services (IHSS);
3. Approve Revisions Related to Cal MediConnect to CalOptima's Fiscal Year (FY) 2013-14 Budget; and
4. Authorize the CEO to develop and/or update policies necessary to meet Cal MediConnect participation requirements and implement the program's benefit set.

Background
In June 2012, Senate Bill 1008 (2012) and SB 1036 (2012) authorized the Coordinated Care Initiative (CCI). The CCI is composed of two (2) key components that will work in tandem to improve care coordination and integration.

1. Cal MediConnect: No sooner than April 1, 2014, the state will begin a three (3) year federal-state demonstration program in eight (8) counties. Individuals with Medicare and Medi-Cal (i.e., dual eligible beneficiaries) will receive coordinated medical, behavioral health, institutional long-term care, and home and community based services through a single Medi-Cal managed care plan. The participating counties are: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside, and San Bernardino.

2. Managed Medi-Cal Long-Term Supports and Services (MLTSS): No sooner than April 1, 2014, all Medi-Cal beneficiaries, including dual eligible beneficiaries, will receive long-term services and supports and Medi-Cal wrap-around benefits through a Medi-Cal managed care plan. MLTSS includes institutional long-term care, Community Based Adult Services, Multipurpose Senior Services Program, and IHSS.

   As a County Organized Health System (COHS), CalOptima already serves dual eligible beneficiaries, and provides Medi-Cal wrap-around services to members. In addition, pursuant to SB 94 (2013), DHCS separated the MLTSS component from the Cal MediConnect program. Medi-Cal managed care plans will provide MLTSS as a Medi-Cal benefit to all enrollees even if Cal Medi-Connect does not move forward.

Back to Agenda Back to Item

DHCS initially proposed to implement Cal MediConnect no sooner than January 1, 2014. However, DHCS revised the timeline several times to accommodate ongoing negotiations with CMS and to resolve other implementation issues. On August 13, 2013, DHCS formally announced that Cal MediConnect will begin no sooner than April 1, 2014. Initial enrollment will occur on a passive enrollment basis for a twelve (12) month period, based on the eligible beneficiary's birthday month.

CalOptima's FY 2013-14 Operating Budget projected an increased enrollment of 27,000 members from the Cal MediConnect program through June 30, 2014. Staff will make a downward adjustment to the membership projection due to the delayed implementation date, and anticipates approximately 3,700 members will be passively enrolled each month. Staff will implement strategies to minimize the opt-out rate of the Cal MediConnect program.

The Demonstration Years for the Cal MediConnect program are as follows:

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

On May 3, 2012, your Board approved a pre-implementation budget for the CCI of $373,994 to proceed with the application process to participate in the program. The funds were used to support travel and training, consultant fees, limited term staffing, and outreach and engagement. The budget was for the period of May 3, 2012, through August 31, 2012.

On January 3, 2013, your Board approved additional funding to continue pre-implementation planning for the CCI of $615,000 for a total of $988,994. The funds were used to support professional fees and staffing. To date, approximately ninety-five percent (95%) of the pre-implementation funds have been spent. Based on Board approval, staff has completed all state and federal applications and additional requests, including but not limited to:

Key Deliverables	Date
DHCS Request for Solutions	February 23, 2012
CMS Capitated Financial Alignment Demonstration application	May 23, 2012
Proposed Model of Care	June 29, 2012
Proposed Medication Management Therapy Program	May 6, 2013
Proposed Part D Formulary	May 31, 2013
Proposed Plan Benefit Package	June 3, 2013
Revised Health Service Delivery Tables for Network Validation	June 26, 2013

Key steps and milestones for the Cal MediConnect program are as follows:

Key Steps and Milestones	Date
Finalize Memorandum of Understanding (MOU) (CMS and DHCS)	Executed March 27, 2013

Key Steps and Milestones	Date
Develop final capitation rates	Ongoing since April 23, 2013
Conduct joint readiness assessments (CMS and DHCS)	Initiated March 2013 and ongoing through December 2013 - Desk Review: April 19, 2013 - On-site visit: July 25-26, 2013 - Remote Systems Testing: October 21, 2013 - Network Validation: October 28, 2013 - Pre-Enrollment Validation: November 20, 2013 - Final Readiness report to be issued mid-December 2013
Execute MOUs with relevant county agencies	Completed in July and August 2013
Sign Three-Way contract	December 13, 2013 (electronic signature) December 16, 2013 (hard copy signature)
Sign CDSS contract for IHSS services	Mid-December 2013 (anticipated)
Finalize Plan Benefit Package in CMS system	Mid-December 2013
Implement Cal MediConnect	No sooner than April 1, 2014

On June 6, 2013, your Board approved CalOptima's FY 2013-14 Operating Budget. Staff clarified that the operating budget did not include infrastructure and implementation funding for the Duals Demonstration (i.e., the Cal MediConnect program), and that Staff would present the budget as a separate Board action.

Discussion

Both DHCS and CMS are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of Cal MediConnect. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted, as noted above, from the prior dates shared with the Board in previous meetings. Staff participated in the on-site readiness review July 25-26, 2013.

The next key step is for CalOptima to sign the Three-Way Agreement with CMS and DHCS. Recently, DHCS notified participating plans that the final date by which CMS will require execution of the Agreement is December 10, 2013. Plans, including CalOptima, received the "final" Three-Way Agreement on November 6, 2013 and were advised that they would not be able to negotiate changes to the Agreement. Although the document contains a number of terms that are currently in other program agreements, this was the first time that plans received the document which contains new Cal MediConnect program requirements, Plans had approximately one week to review the document and submit a list of "significant concerns" to the Agreement. DHCS held a conference call with plans on November 20, 2013 to discuss the comments plans submitted. On the call, the DHCS provided clarification on certain terms, but essentially reiterated that the "final" version was, in fact, final. CMS and DHCS issued interim final rates in late October for plans' thirty (30) day review. Additionally, DHCS has indicated that rates may be subject to additional minor revisions prior to the final execution of the Agreement.

Three-Way Cal MediConnect Agreement

The Agreement between DHCS, CMS, and CalOptima outlines the respective obligations for each party to implement the Cal MediConnect program in Orange County. The Agreement contains provisions for CMS

and DHCS to evaluate CalOptima's performance as a Cal MediConnect participating plan, including adherence to federal Medicare and Medicaid laws.

Below are some areas within the Agreement that will have a significant operational and financial impact:

Requirement / Area of Concern	Impact
Benefits and funding streams	The Agreement reflects continued fragmentation of Medicare and Medi-Cal benefits, services, and funding streams will pose operational challenges. Full integration will likely not occur until year 2 of the demonstration.
Care coordination	The Agreement includes extensive care coordination requirements that conflict with the existing Medicare requirements for a plan's Model of Care are included in the Agreement. Specifically, the ten (10) day timeframe to develop Individualized Care Plans (ICPs) for members after completion of the Health Risk Assessment (HRA) is insufficient.
Rate dispute process	The Agreement excludes rates from the dispute process. Requiring participating plans to waive their legal rights to dispute a rate that may be unreasonable or actuarially unsound is particularly problematic in year 2 and 3 of the demonstration.
Quality withholds	There is a lack of specific information on the quality withhold metrics, and how plans will be measured for purposes of earning back the withheld amount based on performance. The agreement lacks a process for plans to provide meaningful input on the performance metrics that will be tied to the quality withholds for each Demonstration year.
IHSS	Plans are required to assume full risk for IHSS provider payments (i.e., wages and benefits, such as health insurance). The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December. CalOptima Board of Directors would likely have to make a "go / no-go" decision on the 3-way contract for Cal MediConnect in December without the opportunity to review the CDSS contract.
After-hours call capacity	Plans cannot leverage current 24-hour Nurse Advice Lines to meet the after-hours call capacity requirement as the after-hours call service needs to be staffed either by a physician or an appropriate licensed professional under his or her supervision.

Requirement / Area of Concern	Impact
Pending contracts and regulatory guidance	The Agreement incorporates requirements to comply with unissued CMS/DHCS guidance. These references in the Agreement are broad and are not limited to indicating that the guidance will do no more than interpret current requirements under State and Federal laws.
Advisory Committee	Requires the formation of a new Advisory Committee to the Board of Directors, which must consist of not more than eleven (11) people, and no less than fifty percent (50%) of the membership of the advisory committee shall be individuals who are users of personal assistance paid for through public or private funds or recipients of IHSS services.

Other issues related to the Three-Way Agreement for Cal MediConnect include:

- Lack of specific information on IHSS;
  - Data sharing issues with the California Department of Social Services (CDSS) for IHSS; and
  - Contract terms for agreement with CDSS. The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December.

- Reporting requirements not yet specified (e.g., network adequacy, performance measures).

Revisions to CalOptima's FY 2013-14 Implementation, Operating, and Capital Budgets
Staff is submitting revisions to the FY 2013-14 Implementation, Operating, and Capital Budget to the BOD for approval with assumptions based on currently available information.

Proposed Budget 1/1/14 – 6/30/14			
	Implementation	**Operational**	**Total**
Average Monthly Enrollment	N/A	7,118	7,118
Revenue	$0	$43,130,331	$43,130,331
Medical Costs	$2,845,316	$38,414,385	$41,259,701
Administrative Costs	$2,879,267	$4,069,166	$6,948,433
Operating Income/(Loss)	($5,724,583)	$646,780	($5,077,803)
Medical Loss Ratio (MLR)	N/A	89.1%	95.7%
Administrative Loss Ratio (ALR)	N/A	9.4%	16.1%
Capital – Hardware/Software			$1,100,000

Enrollment Assumptions:
- Begins April 1, 2014 with an estimated 3,680 members
- Assumes a pre-enrollment opt-out rate of 20% and disenrollment rate of 5%

- CY 2014 enrollment will consist of FFS Medicare membership, since Medicare Advantage enrollees are allowed to stay with existing plan through Dec 2014

Revenue Assumptions:
- Bases Medicare rates on draft rates provided in October 2013
- Bases Medi-Cal rates on draft rates provided on November 20, 2013
- Estimates total revenue of $2,019.74 per member per month
- Medicare Part A/B and Part D rates utilizes a base rate and applies a risk adjustment factor (similar to OneCare revenue)
- Medi-Cal rate is a blended rate of four population cohorts: LTC, HCBS High, HCBS Low, and Community Well
- Adjusts rates for savings targets that escalate from 1.4% to 5.5% over the next three and a half years

Medical Cost Assumptions:
- Assumes an average provider capitation rate of 37.5% of Medicare Part A/B premium
- Uses current OneCare medical utilization and unit cost rates as a proxy
- Assumes an MLR of 85.3% on prescription drug benefits
- Assumes an MLR of 90.3% on Medi-Cal wrap-around benefits
- Excludes supplemental benefits with the exception of mental health and transportation services
- Includes program guidelines that require higher levels of Case Management and Health Services
- Estimates eighty-two (82) FTE's are scheduled over the remainder of the year

Administrative Cost Assumptions:
- Includes implementation costs of $5.7 million to prepare the organizations processes, policies, and staff for a targeted go-live date of April 1, 2014
- Program guidelines specify staffing requirements, such as Compliance and Customer Service
- Estimates sixty-three (63) FTE's are scheduled over the remainder of the year
- First twelve (12) months of the program will require higher than standard level of cost for initial items such as member and provider mailings as well as staff recruitment and training. These costs are staged in to occur approximately three (3) months prior to the member enrollment.

Capital Assumptions:
- Includes hardware and software required to support the increase in staffing and projected membership population

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
CCMS (Medical Database)	$ 222,300	20%
Facets Upgrades	204,300	19%
Backup Environment	67,240	6%
Core Infrastructure	58,020	5%
Data Warehouse	43,000	4%

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
Misc (Network Costs)	505,140	46%
Total	$ 1,100,000	100%

The Proposed budget includes hardware, software, and professional fees.

Next Steps:
After receipt and review of the Three-Way Agreement and analysis of the interim final rates, Staff recommends the BOD to authorize the Chairman to execute the Three-Way Agreement for CalOptima to participate in Cal MediConnect.

Concurrently, Staff will continue to prepare for the implementation of Cal MediConnect and Managed MLTSS.

Approval of the proposed actions and the Board Chair's execution of the three-way agreement with CMS and DHCS will commit CalOptima to participating in the Cal MediConnect Program.

Fiscal Impact
As outlined above, the proposed revisions to the CalOptima FY 2013-14 Implementation and Operating Budget reflect a deficit of $5.1 million and a Capital Budget of $1.1 million.

Rationale for Recommendation
The DHCS proposal to implement the CCI aligns with CalOptima's long standing commitment to better integrate acute and long term care services. This integration initiative provides CalOptima an opportunity to work with community stakeholders to design a system that fully integrates the administrative and financial responsibilities for Medi-Cal and Medicare covered services and achieve its acute and long term care integration goals.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/27/2013*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

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- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: January 8, 2019

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer R. Shapiro, Acting Director, Medicare Plan Payment Group

SUBJECT: **Release of 2019 MIPS Payment Adjustment Data File**

The Centers for Medicare & Medicaid Services (CMS) has uploaded to the Health Plan Management System (HPMS) the Merit-based Incentive Payment System (MIPS) Payment Adjustment Data File for payment year 2019. Medicare Advantage organizations (MAOs) can use the information in the file to determine the amount of the MIPS payment adjustment that applies to their payments for Medicare Part B covered professional services furnished by out-of-network MIPS eligible clinicians.

For guidance on when and how the MIPS payments apply to MAOs' payments to MIPS eligible clinicians, please see the April 27, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments" and the November 8, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance."

File Access

The 2019 MIPS Payment Adjustment Data File has been added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). After navigating to the "Incentive Payments" section, a user may download the file by selecting "MIPS Payment Adjustment Data File" under Step One, "2019" under Step Two, and "Download" under Step Three.

Due to the sensitivity of some of the information provided in the file, only the MAO's Medicare Compliance Officer will be able to access and download it. The Compliance Officer must be a registered HPMS user in order to obtain the file.

Identifying the Applicable MIPS Adjustment Percentage

The MIPS Payment Adjustment Data File consists of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)

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- MIPS adjustment percentage
- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see the attached Appendix.

An MAO can identify the applicable MIPS adjustment percentage for a MIPS eligible clinician by matching the clinician's billing TIN/NPI combination to a TIN/NPI combination in the MIPS Payment Adjustment Data File. If an exact match for the billing TIN/NPI combination does not appear in the data file, the MAO should determine whether the NPI appears in combination with another TIN and, if so, apply the MIPS adjustment percentage associated with that TIN/NPI combination. If the NPI appears in more than one TIN/NPI combination in the data file, the MAO should apply the MIPS adjustment percentage for the TIN/NPI combination that results in the greatest total payment amount.

Additional Information

If you encounter technical difficulties when downloading the MIPS Payment Adjustment Data File from HPMS, you may contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028.

If the "Incentive Payments" hyperlink does not appear in the HPMS Data Extract Facility, you must send a request for additional access to hpms_access@cms.hhs.gov. Please note that information in the MIPS Payment Adjustment Data File is considered sensitive and may require additional levels of approval.

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

Appendix

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Policy:	HH.2005Δ
Title:	**Corrective Action Plan**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/ Richard Sanchez 12/07/2020*
Effective Date:	11/01/1998
Revised Date:	12/03/2020

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE
- ☐ Administrative

I. PURPOSE

This policy defines the requirements for CalOptima and its First Tier, Downstream, and Related Entities (FDRs) for development and submission of an Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) for areas of non-compliant performance, as identified by CalOptima's Office of Compliance.

II. POLICY

A. CalOptima's Office of Compliance shall conduct Auditing, operational Monitoring, and investigations of internal CalOptima departments and its FDRs to ensure compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements related to CalOptima programs.

B. CalOptima's Office of Compliance may require that an internal department or FDR develop an ICAP or CAP response based on the identified area(s) of non-compliance.

C. CalOptima's Office of Compliance shall require CalOptima internal departments and FDRs to bring their operations into full compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements, which CalOptima or its regulators have identified as non-compliant, within time frames established by CalOptima's Office of Compliance.

D. An internal department or FDR shall develop, submit, and take corrective action under an approved ICAP or CAP response in the time and manner required by CalOptima's Office of Compliance.

1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP or CAP request may lead to further action.

2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP, or CAP, request may lead to further action. CalOptima may impose Sanctions for the underlying non-compliant performance that gave rise to the ICAP or CAP request, or the failure to develop, submit, and meet the requirements of the ICAP or CAP request, in accordance with CalOptima Policy HH.2002Δ: Sanctions.

III. PROCEDURE

A. Basis for an ICAP or CAP

1. CalOptima's Office of Compliance shall routinely Monitor performance metrics, conduct routine, or focused, Audits, and conduct ongoing Monitoring and investigations of reported non-compliance for internal departments, or FDRs, through a variety of mechanisms.

    a. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of Audits conducted by federal and state regulatory agencies, including, but not limited to the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Managed Health Care (DMHC).

    b. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of an ICAP/CAP request, or other corrective action, that CalOptima receives from a federal or state regulatory agency that is directly related to the operations of an internal department or FDR.

2. In the event that CalOptima's Office of Compliance determines an internal department, or FDR, has failed to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements, the Office of Compliance may issue an ICAP, or CAP request, to address the problem. CalOptima's Office of Compliance shall coordinate its efforts with CalOptima's Human Resources Department in the event that an ICAP or CAP potentially warrants Employee disciplinary action.

B. ICAP and CAP Issuance and Requirements

1. CalOptima's Office of Compliance shall utilize a standardized ICAP and CAP request template.

2. Non-compliance with specific requirements that have the potential to cause significant Member harm, or place CalOptima's accreditation, participation, and/or contractual status with regulatory agencies in jeopardy will require an ICAP response.

    a. If the finding requires an ICAP request, as determined by CalOptima's Office of Compliance, the internal department or FDR is required to cease non-compliant activities within two (2) business days of receiving the ICAP request.

    b. The internal department or FDR shall provide a written response within three (3) business days of receiving an ICAP request, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the ICAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima's Office of Compliance.

3. A CAP request is the result of material non-compliance with specific requirements that does not rise to the level of an ICAP request.

    a. The internal department or FDR is required to respond to the CAP request within fourteen (14) calendar days. CalOptima's Compliance Officer or Designee may authorize extensions to this timeline on a case-by-case basis. Following the acceptance of the CAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima's Office of Compliance.

4. An ICAP or CAP response shall include the following elements:

a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training, and systems that failed;

b. Steps taken to resolve the deficiency;

c. Steps taken to avoid reoccurrence;

d. Method for implementation and completion of ICAP response or CAP response;

e. Individual(s) responsible for implementation of the ICAP response or CAP response;

f. An attestation by the internal department or FDR conveying a plan to remedy its identified deficiencies; and

g. ICAP response or CAP response completion date(s), as applicable.

C. Unacceptable Resolution to an ICAP or CAP

1. If the resolution to the deficiency is unacceptable or the internal department or FDR fails to respond, CalOptima's Office of Compliance shall issue a written notice to the internal department or the FDR, which shall include:

a. A summary of previous outreach and required action(s);

b. An explanation of why that the resolution was not acceptable, or why a response was not received;

c. A revised response timeline of two (2) business days for an ICAP;

i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or Designee.

d. A revised response timeline of five (5) business days for a CAP;

i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or Designee.

e. Explain the possible consequences, specific to the nature of the issue and degree of completeness in accordance with CalOptima Policy HH.2002Δ: Sanctions;

f. Possibility of escalating to the department's Chief, or the FDR's Chief Executive Officer (CEO) or their Designee; and

g. Possibility of referral to the Audit & Oversight Committee and the Compliance Committee.

D. Acceptable Resolution with ICAP or CAP Requirements

1. A response may be accepted once all requirements outlined in Section III.B.4. of this Policy are fulfilled. If an ICAP or CAP response requires Monitoring or a focused Audit, the ICAP or CAP response shall not be closed until the remediation(s) implemented have been validated by the Office of Compliance and demonstrate that the issue will not recur.

a. A response may be accepted and closed simultaneously if Monitoring or a focused Audit is not required.

2. If the resolution to the deficiency is deemed acceptable by CalOptima's Compliance Officer or Designee, CalOptima's Office of Compliance may issue a written notification of acceptance, which shall include:

   a. An acknowledgement of acceptance;

   b. A description of follow up actions which shall include, but is not limited to:

      i. Submission of finalized documentation; and/or

      ii. Focused Audit, as described in Section III.E. of this Policy; and/or

      iii. Monitoring, as deemed appropriate by CalOptima's Office of Compliance, and as described in Section III.F. of this Policy.

3. If the resolution to the deficiency is accepted and deemed sufficient by CalOptima's Compliance Officer or Designee, CalOptima's Office of Compliance shall issue a written notification of closure, which shall include:

   a. An acknowledgement of closure;

   b. The effective date of closure; and

   c. Consequences of repeat deficiencies.

E. Focused Audits

1. CalOptima's Office of Compliance may conduct a focused Audit of an internal department or FDR to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima's Office of Compliance shall notify the internal department or FDR of the scope, Audit period, and Audit deliverables that shall be required to complete the focused Audit.

3. CalOptima's Office of Compliance may continue to Monitor and/or Audit an internal department or FDR for performance of issues and/or functions related to the ICAP or CAP request.

F. Monitoring Period

1. CalOptima's Office of Compliance may conduct Monitoring of the internal department's or FDR's resolution to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima's Office of Compliance shall Monitor the resolution for a predetermined time frame, as established by CalOptima's Office of Compliance.

3. CalOptima's Office of Compliance shall notify the internal department, or FDR, of the scope, Monitoring period, and deliverables that shall be required to complete the Monitoring.

4. CalOptima's Office of Compliance may continue to Monitor and/or Audit an internal department's or FDR's performance of issues and/or functions related to the ICAP or CAP request.

G. Failure to Maintain Adequate Resolution

1. If during the Monitoring period or the focused Audit the internal department or FDR fails to maintain the remedies in place, CalOptima's Office of Compliance may issue the internal department or FDR an ICAP or CAP request, as appropriate.

2. If an ICAP request is issued, the internal department or FDR shall be required to resolve the issue within two (2) business days from the re-issuance of the finding.

   a. Extensions to this timeline may be authorized on a case-by-case basis by the Compliance Officer, or Designee.

3. The ICAP request shall require the information as described in Section III.B.4. of this Policy.

H. ICAP and CAP Tracking and Reporting

1. CalOptima's Office of Compliance shall track all CAP and ICAP requests issued utilizing a standardized tool.

2. CalOptima's Office of Compliance shall report the status of all CAP/ICAP requests to the Audit & Oversight Committee and the Compliance Committee.

3. In the event that CalOptima's Office of Compliance issues an ICAP request with respect to the CalOptima Medi-Cal Program, the Regulatory Affairs & Compliance Department shall report the issue to CalOptima's DHCS Contract Manager for Medi-Cal within three (3) business days of issuance.

4. If CalOptima's internal department, or FDR, has repeat deficiencies, the issue(s) shall be reported to the Audit & Oversight Committee and the Compliance Committee by the Office of Compliance for further action.

IV. ATTACHMENT(S)

A. ICAP/CAP Request Template

V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy HH.2002Δ: Sanctions
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Department of Health Care Services (DHCS) All Plan Letter 17-004: Subcontractual Relationships and Delegation
H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9

J. Title 22, California Code of Regulations (CCR), §51301 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
08/02/2018	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1998	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	10/01/2002	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Effective	08/01/2005	MA.9104	Corrective Action Plan	OneCare
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	08/01/2008	MA.9104	Corrective Action Plan	OneCare
Revised	04/01/2013	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare
Revised	04/01/2014	MA.9104	Corrective Action Plan	OneCare
Revised	12/01/2014	MA.9104	Corrective Action Plan	Cal MediConnect OneCare PACE
Revised	09/01/2015	HH.2005	Corrective Action Plan	Medi-Cal
Revised	09/01/2015	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	08/02/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Audit & Oversight Committee	A subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in the AOC charter.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier Entities and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
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.
Employee	For purposes of this policy, any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDRs)	First Tier Entity: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program. Downstream Entity: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services. Related Entity: Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two-thousand five-hundred dollars ($2,**500)** during a contract period.

Term	Definition
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Immediate Corrective Action Plan (ICAP) Request	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	A beneficiary who is enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a First Tier Entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

AMENDMENT {XXXXXX} TO

CAL MEDICONNECT PHYSICIAN GROUP SERVICES CONTRACT

This Amendment {XXXXX} to the Cal MediConnect Physician Group Services Contract ("Amendment") is effective as of January 1, 2022, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, {_____} ("Physician Group"), with respect to the following facts:

RECITALS

A. Physician Group and CalOptima have entered into a Cal MediConnect Physician Group Services Contract ("Contract") for the provision of specified covered services to CalOptima members in identified CalOptima Programs.

B. CalOptima and Physician Group desire to amend the Contract to extend the term of the Contract and revise the Corrective Action Plan time frame.

NOW, THEREFORE, the parties agree as follows:

1. Section 11.1 "Term of the Contract" shall be deleted in its entirety and replaced with the following:

   "11.1 **Term of Contract.** This Contract will commence on June 1, 2015 (Effective Date") and will remain in effect until December 31, 2022."

2. Section 11.3.1 shall be deleted in its entirety and replace with the following:

   "11.3.1 CalOptima may require a CAP if it receives a substantiated complaint or grievance related to the Physician Group or any Downstream Entities' non-compliance with statutory, regulatory, contractual, policy or other requirements in accordance with the CAP timing, content and other requirements of CalOptima's corrective action plan and other applicable policies.

3. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS THEREOF, CalOptima and {Insert HN Name Here} have executed this Amendment {Insert Amendment # Here}:

FOR PHYSICIAN GROUP:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	_____
PRINT NAME	PRINT NAME
_____	_____
TITLE	TITLE
_____	_____
DATE	DATE

Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

21. Consider Authorizing Amendments to Extend the OneCare Connect Cal MediConnect Plan Health Network Contracts for ARTA Western California Inc., Monarch Health Plan Inc., and Talbert Medical Group P.C., and Align the Corrective Action Plan Section of the Contract with Current Policy

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Michelle Laughlin, Executive Director Network Operations, (657) 900-1116

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the OneCareConnect health network contracts for ARTA Western California Inc. (ARTA), Monarch Health Plan Inc. (Monarch), and Talbert Medical Group P.C. (Talbert), as follows:

1. Exercise the final one-year extension option of the health network contracts agreements through December 31, 2022; and
2. Align the Corrective Action Plan section of the contract with current policy

Background

In 2014, the State launched Cal MediConnect (CMC), designed to serve members eligible for both Medicare and Medi-Cal, in a dual health plan covering medical, prescription drug, and long-term services and support. CMC was initially launched as a three-year demonstration program across eight counties in California. In Orange County, CalOptima provides health care services to CMC beneficiaries via OneCare Connect (OCC). OCC was established with authorization through a three-way contract between CalOptima, the Department of Health Care Services (DHCS), and the Centers for Medicare & Medicaid Services (CMS). The CalOptima Board of Directors (Board) initially authorized this three-way contract at its December 5, 2013, meeting, with CalOptima providing OCC benefits as of July 1, 2015.

At its September 2017 meeting, the Board authorized the execution of a new three-way contract between CalOptima, CMS and DHCS to extend OCC for an additional two years, through December 31, 2019. At its October 3, 2019, meeting, the Board authorized execution of a third three-way contract, which became effective September 1, 2019. Among key changes it included was the extension of the CMC Demonstration Period through December 31, 2022, renewable in one-year terms. With the sunsetting of the Cal MediConnect demonstration program at the end of calendar year 2022, OCC will sunset. CalOptima plans to transition all OCC members as of January 1, 2023, to OneCare (HMO SNP). This includes expanding the OneCare provider network to accommodate the increased membership that will take effect as OCC ends.

Effective July 1, 2015, CalOptima contracted with its OCC delegated health networks for an initial period through December 31, 2017. The Board approved an amendment for a one-year

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extension, to be effective January 1, 2018, with option to extend an additional year, ending December 31, 2019. The Board approved two additional amendments to extend the contract, to be effective January 1, 2020, through December 31, 2020, as well as January 1, 2021 through December 31, 2021.

Discussion

Health Network Contract Extensions

With OCC entering its third year of the three-year extension allowance for the three-way contract with DHCS and CMS, CalOptima needs to maintain its contractual relationships with the health networks providing health care services to OCC members. CalOptima contracts with ARTA, Monarch, and Talbert health networks for OCC, under the Shared Risk (SR) and Health Maintenance Organization (HMO) contract models. In coordination with the extension of the demonstration period, staff is seeking authorization to extend the ARTA, Monarch, and Talbert health network contracts through December 31, 2022.

Align Corrective Action Plan Section of the Contract with Current Policy

CalOptima Policy HH.2005 "Corrective Action Plan" serves as a guideline for addressing Corrective Action Plans (CAPs) issued by CalOptima's Office of Compliance. Previously there was a 30-calendar day period allowed for the internal department or First Tier, Downstream, and Related Entities to respond to a CAP. As a result of policy updates, this response time has been modified to 14 calendar days. Staff recommend amending the OCC health network contracts for ARTA, Monarch, and Talbert to align the corrective action plan section of the contract with current policy

Fiscal Impact

The CalOptima Fiscal Year (FY) 2021-22 Operating Budget approved by the Board on June 3, 2021, incorporated total OCC health network capitation expenses of $146.8 million. The recommended action to extend the existing health network contracts through June 30, 2022, is a budgeted item, with no additional fiscal impact expected. Management plans to include revenue and expenses for the period of July 1, 2022, through December 31, 2022, as related to the proposed contract extensions, in the CalOptima FY 2022-23 Operating Budget.

The recommended action to amend the OCC Health Network contracts related to CAP response time is operational in nature, with no anticipated fiscal impact beyond what was incorporated in the CalOptima FY 2021-22 Operating Budget.

Rationale for Recommendation

The recommended contract changes are intended to ensure that the contractual relationships with the ARTA, Monarch, and Talbert health networks are maintained and that contracts are aligned with current policy.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated November 5, 2020: Consider Authorizing Extension of, and Amendments to, the Cal MediConnect (OneCare Connect) Health Network Contracts
3. Previous Board Action dated November 7, 2019: Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, except those associated with AltaMed Health Services Corporation, to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services
4. Previous Board Action dated November 7, 2019: Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services
5. CalOptima Policy & Procedure HH.2005: Corrective Action Plan
6. Proposed OneCare Connect Health Network Contract Amendment

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
November 5, 2020	Consider Authorizing Extension of, and Amendments to, the Cal MediConnect (OneCare Connect) Health Network Contracts		
November 7, 2019	Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, Except Those Associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contract to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services		
November 7, 2019	Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts Associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contract to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services		
November 1, 2018	Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts		

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September 7, 2017	Authorize and Direct Execution of a New Three-Way Contract Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program		
December 5, 2013	Consider Participation in the Cal MediConnect Program		

/s/ Richard Sanchez *10/28/2021*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
13. Consider Authorizing Extension of, and Amendments to, the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Action
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the OneCare Connect Health Network contracts to extend the term through December 31, 2021 and to address modified and additional terms.

Background
In 2014, the State launched Cal MediConnect (CMC), designed to serve members eligible for both Medicare and Medi-Cal, in a dual health plan covering medical, prescription drug, and long-term services and support. CMC was initially launched as a three-year demonstration program across eight counties in California. At the local level, CalOptima provides health care services to CMC beneficiaries in Orange County, via its OneCare Connect (OCC) program. OCC was executed with authorization through a three-way contract between CalOptima, the Department of Health Care Services (DHCS), and the Centers for Medicare & Medicaid Services (CMS). The CalOptima Board of Directors (Board) initially authorized this agreement at its December 5, 2013 meeting, with CalOptima providing OCC benefits as of July 1, 2015.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC/OCC program for an additional two years, through December 31, 2019. At its October 3, 2019 meeting, the Board authorized execution of a third Three-Way agreement, which became effective September 1, 2019. Among key changes it included the extension of the CMC Demonstration Period through December 31, 2022, renewable in one-year terms.

In support of CMC/OCC, CalOptima has contracted with its delegated Health Networks to manage health care services for OCC members as of the program's launch. At the Board's November 2018 meeting, staff received authorization to extend the Health Network contracts for one year, through December 31, 2019. On November 7, 2019, the Board authorized staff to exercise the first of three one-year (1) extension options in each of the Health Network contracts, extending them through December 31, 2020.

Discussion

Health Network Contract Extensions
With OCC entering its second year of the three-year extension granted for the Three-Way agreement with DHCS, CalOptima needs to maintain its contractual relationship with the Health Networks providing health care services to OCC members. In coordination with the extension of the

demonstration period, staff is seeking authorization to exercise a one-year extension option of the Health Networks' agreements through December 31, 2021.

Capitation Rate Change for Hospital and Shared Risk Pool Funding
Staff seeks authorization to amend the OCC Health Network contracts to adjust the Hospital capitation rates and Shared Risk Pool funding to more appropriately reflect delegated risk assigned to Health Networks, and as included in the CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020.

Division of Financial Responsibility (DOFR)
Staff seeks authorization to implement changes to the DOFR, including changing coverage of Methadone Clinic services to CalOptima Responsibility as a Medicare covered service. Additionally, Worldwide Coverage has been added as a Medicare covered service.

Change Timeframe for Termination Without Cause
Staff also seeks authorization to amend the notice period for Termination Without Cause from 120 days to 180 days. This change allows for a more appropriate time frame related to activities involved with a termination including, but not limited to, reassignment of members, issuing new ID cards, member education, and operational systems-related changes.

Fiscal Impact
The CalOptima FY 2020-21 Operating Budget approved by the Board on June 4, 2020 incorporated OCC Health Network capitation expenses of $133 million, including updated Hospital capitation rates and their associated impact to Shared Risk Pool funding. The recommended action to extend the existing Health Network contracts through June 30, 2021 is a budgeted item, with no additional fiscal impact. Management plans to include revenue and expenses for OCC for the period of July 1, 2021 through December 31, 2021, as related to the contract extensions, in the CalOptima FY 2021-22 Operating Budget.

The recommended action to amend the OCC Health Network contracts to add the recommended contract language is budget neutral. The addition of language related to the termination without cause provision is operational in nature, with no anticipated fiscal impact beyond what was incorporated in the CalOptima FY 2020-21 Operating Budget. The proposed changes to the DOFR are not anticipated to have a material impact to CalOptima's financials.

Rationale for Recommendation
The recommended contract changes are intended to ensure that the contractual relationships with the Health Networks serving CalOptima's OCC members are maintained, and that contracts are aligned with current operational procedures.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Previous Board Action dated November 7, 2019; "Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services."
3. Previous Board Action dated September 7, 2017; "Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program"
4. Previous Board Action dated November 7, 2019; "Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, except those associated with AltaMed Health Services Corporation, to Extend them and Incorporate Oher Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services"

/s/ Richard Sanchez — *10/28/2020*
Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western Medical Group	1665 Scenic Ave Dr., #100	Costa Mesa	CA	92626
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Monarch Medical Group	11 Technology Dr.	Irvine	CA	92618
Talbert Medical Group	1665 Scenic Ave Dr., Ste #100	Costa Mesa	CA	92626
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868
AltaMed Health Services	2040 Camfield Ave.	Los Angeles	CA	90040
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates	10855 Business Center Dr. Ste. C	Cypress	CA	90630
Prospect Medical Group	600 City Parkway West Ste. 800	Orange	CA	92868

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

Contact

Michelle Laughlin, Executive Director, Network Operations (714) 246-8400
Nancy Huang, Interim Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the OneCare Connect Health Network contracts with AltaMed Health Services Corporation to:

i. Extend the OneCare Connect Health Network contract through and including December 31, 2020;
ii. Add any necessary language provisions required based on the Three-Way Cal MediConnect contract (Three-Way Agreement) between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements, including language reflecting changes related to the Merit-based Incentive Payments System (MIPS) program; and
iii. Clarify access standards for prenatal care.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (CMC) OneCare Connect beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

Cal MediConnect was launched in 2014 as a three-year demonstration program implemented across eight counties. OneCare Connect (OCC) was launched July 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated Health Networks to manage services to the network's assigned membership.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019. At its November 2018 meeting, the Board authorized CalOptima to extend the Health Network contracts for one year through December 31, 2019.
At its October 3, 2019 meeting, the Board authorized execution of the newest version of the three-way agreement, which became effective September 1, 2019. Among the key changes of the new agreement was extension of the Cal MediConnect demonstration period through, December 31, 2022, in one-year

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terms. In accordance with this change, staff is seeking authorization to extend the Health Network agreements for an additional year through December 31, 2020.

Discussion

Language Provisions; Agreement with CMS and DHCS

Contract amendments will be required to include provisions to address technical revisions and any other new/revised requirements from the new Three-Way Agreement that are applicable to the OneCare Connect Health Networks. To be in compliance with the most current version of the Three-Way Agreement received from DHCS, effective September 1, 2019, staff seeks authority to amend OneCare Connect Health Network contracts to ensure contracted OCC Health Networks ensure that providers are enrolled with DHCS as Medicaid providers consistent with all Medicaid enrollment requirements. Other changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Merit-based Incentive Payment Systems (MIPS)

In accordance with the Medicare Access and CHIP Reauthorization Act of 2015 Quality Payment Program memorandum and CalOptima Policies and Procedures, Health Networks implemented the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. This provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Payment to health networks is contingent upon annual receipt of their provider payment adjustment confirmation report, which identifies and reports all claims qualifying for MIPS payment adjustments. Health Networks are required to submit their adjustment reports on an annual basis, starting July 2020. For dates of service January 1, 2019 through December 31, 2019, payment year is 2021. Staff seeks authority to amend contracts to include language in support of the MIPS payment adjustments to the OCC Health Networks to remain in compliance with this CMS-mandated program.

Access Standards for Prenatal Care

As it relates to maternity services and access standards for prenatal care, the OneCare Connect Contract will be updated to be consistent with CalOptima's Medi-Cal Health Network contracts. The Medi-Cal Health Network contract language ensures that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for prenatal services and ensure that Physician Groups have a process in place for follow-up on Member missed appointments.

Summary of Recommendations

Staff seeks Board authorization to amend the Health Network agreements as needed to extend and add any necessary language provisions required by the Three-Way Agreement, and to include language supporting the provision for MIPS, ACOG and GEMT.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect Health Network capitation expenses of $131 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The

recommended action to renew the existing Health Network contracts through June 30, 2020 is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extensions, in the CalOptima FY 2020-21 Operating Budget.

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OCC members is maintained, allows flexibility to modify OCC Health Network contracts as needed based on CalOptima's Three-Way Agreement with DHCS and CMS, support CalOptima's payment obligations under the MIPS program, and ensure access standards for prenatal care are aligned with the most current ACOG standards and guidelines.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated December 5, 2013; Consider Participation in the Cal MediConnect Program
3. Board Action dated September 7, 2017; Authorize and Direct Execution of a New Three-Way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program
4. Board Action dated November 1, 2018; Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts
5. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
6. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
7. CMS Release of 2019 MIPS Payment Adjustment Data File

/s/ Michael Schrader — *10/30/2019*

Authorized Signature — **Date**

AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. C. Consider Participation in the Cal MediConnect Program

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400
Patti McFarland, Chief Financial Officer, (714) 246-8400

Recommended Actions
Consider the following required actions to participate in the Cal MediConnect Program:
1. Authorize and Direct the Chairman of the Board of Directors to Execute the Three-Way Agreement between the California DHCS, CMS and CalOptima for Cal MediConnect, subject to the interim final rates that will not harm the financial viability of CalOptima and reasonable and expected requirements related to operations and reporting;
2. Authorize and Direct the Chairman of the Board of Directors to Execute the California Department of Social Services' (CDSS) Contract for In-Home Supportive Services (IHSS);
3. Approve Revisions Related to Cal MediConnect to CalOptima's Fiscal Year (FY) 2013-14 Budget; and
4. Authorize the CEO to develop and/or update policies necessary to meet Cal MediConnect participation requirements and implement the program's benefit set.

Background
In June 2012, Senate Bill 1008 (2012) and SB 1036 (2012) authorized the Coordinated Care Initiative (CCI). The CCI is composed of two (2) key components that will work in tandem to improve care coordination and integration.

1. Cal MediConnect: No sooner than April 1, 2014, the state will begin a three (3) year federal-state demonstration program in eight (8) counties. Individuals with Medicare and Medi-Cal (i.e., dual eligible beneficiaries) will receive coordinated medical, behavioral health, institutional long-term care, and home and community based services through a single Medi-Cal managed care plan. The participating counties are: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside, and San Bernardino.

2. Managed Medi-Cal Long-Term Supports and Services (MLTSS): No sooner than April 1, 2014, all Medi-Cal beneficiaries, including dual eligible beneficiaries, will receive long-term services and supports and Medi-Cal wrap-around benefits through a Medi-Cal managed care plan. MLTSS includes institutional long-term care, Community Based Adult Services, Multipurpose Senior Services Program, and IHSS.

   As a County Organized Health System (COHS), CalOptima already serves dual eligible beneficiaries, and provides Medi-Cal wrap-around services to members. In addition, pursuant to SB 94 (2013), DHCS separated the MLTSS component from the Cal MediConnect program. Medi-Cal managed care plans will provide MLTSS as a Medi-Cal benefit to all enrollees even if Cal Medi-Connect does not move forward.

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DHCS initially proposed to implement Cal MediConnect no sooner than January 1, 2014. However, DHCS revised the timeline several times to accommodate ongoing negotiations with CMS and to resolve other implementation issues. On August 13, 2013, DHCS formally announced that Cal MediConnect will begin no sooner than April 1, 2014. Initial enrollment will occur on a passive enrollment basis for a twelve (12) month period, based on the eligible beneficiary's birthday month.

CalOptima's FY 2013-14 Operating Budget projected an increased enrollment of 27,000 members from the Cal MediConnect program through June 30, 2014. Staff will make a downward adjustment to the membership projection due to the delayed implementation date, and anticipates approximately 3,700 members will be passively enrolled each month. Staff will implement strategies to minimize the opt-out rate of the Cal MediConnect program.

The Demonstration Years for the Cal MediConnect program are as follows:

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

On May 3, 2012, your Board approved a pre-implementation budget for the CCI of $373,994 to proceed with the application process to participate in the program. The funds were used to support travel and training, consultant fees, limited term staffing, and outreach and engagement. The budget was for the period of May 3, 2012, through August 31, 2012.

On January 3, 2013, your Board approved additional funding to continue pre-implementation planning for the CCI of $615,000 for a total of $988,994. The funds were used to support professional fees and staffing. To date, approximately ninety-five percent (95%) of the pre-implementation funds have been spent. Based on Board approval, staff has completed all state and federal applications and additional requests, including but not limited to:

Key Deliverables	Date
DHCS Request for Solutions	February 23, 2012
CMS Capitated Financial Alignment Demonstration application	May 23, 2012
Proposed Model of Care	June 29, 2012
Proposed Medication Management Therapy Program	May 6, 2013
Proposed Part D Formulary	May 31, 2013
Proposed Plan Benefit Package	June 3, 2013
Revised Health Service Delivery Tables for Network Validation	June 26, 2013

Key steps and milestones for the Cal MediConnect program are as follows:

Key Steps and Milestones	Date
Finalize Memorandum of Understanding (MOU) (CMS and DHCS)	Executed March 27, 2013

Key Steps and Milestones	Date
Develop final capitation rates	Ongoing since April 23, 2013
Conduct joint readiness assessments (CMS and DHCS)	Initiated March 2013 and ongoing through December 2013 - Desk Review: April 19, 2013 - On-site visit: July 25-26, 2013 - Remote Systems Testing: October 21, 2013 - Network Validation: October 28, 2013 - Pre-Enrollment Validation: November 20, 2013 - Final Readiness report to be issued mid-December 2013
Execute MOUs with relevant county agencies	Completed in July and August 2013
Sign Three-Way contract	December 13, 2013 (electronic signature) December 16, 2013 (hard copy signature)
Sign CDSS contract for IHSS services	Mid-December 2013 (anticipated)
Finalize Plan Benefit Package in CMS system	Mid-December 2013
Implement Cal MediConnect	No sooner than April 1, 2014

On June 6, 2013, your Board approved CalOptima's FY 2013-14 Operating Budget. Staff clarified that the operating budget did not include infrastructure and implementation funding for the Duals Demonstration (i.e., the Cal MediConnect program), and that Staff would present the budget as a separate Board action.

Discussion

Both DHCS and CMS are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of Cal MediConnect. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted, as noted above, from the prior dates shared with the Board in previous meetings. Staff participated in the on-site readiness review July 25-26, 2013.

The next key step is for CalOptima to sign the Three-Way Agreement with CMS and DHCS. Recently, DHCS notified participating plans that the final date by which CMS will require execution of the Agreement is December 10, 2013. Plans, including CalOptima, received the "final" Three-Way Agreement on November 6, 2013 and were advised that they would not be able to negotiate changes to the Agreement. Although the document contains a number of terms that are currently in other program agreements, this was the first time that plans received the document which contains new Cal MediConnect program requirements, Plans had approximately one week to review the document and submit a list of "significant concerns" to the Agreement. DHCS held a conference call with plans on November 20, 2013 to discuss the comments plans submitted. On the call, the DHCS provided clarification on certain terms, but essentially reiterated that the "final" version was, in fact, final. CMS and DHCS issued interim final rates in late October for plans' thirty (30) day review. Additionally, DHCS has indicated that rates may be subject to additional minor revisions prior to the final execution of the Agreement.

Three-Way Cal MediConnect Agreement

The Agreement between DHCS, CMS, and CalOptima outlines the respective obligations for each party to implement the Cal MediConnect program in Orange County. The Agreement contains provisions for CMS

and DHCS to evaluate CalOptima's performance as a Cal MediConnect participating plan, including adherence to federal Medicare and Medicaid laws.

Below are some areas within the Agreement that will have a significant operational and financial impact:

Requirement / Area of Concern	Impact
Benefits and funding streams	The Agreement reflects continued fragmentation of Medicare and Medi-Cal benefits, services, and funding streams will pose operational challenges. Full integration will likely not occur until year 2 of the demonstration.
Care coordination	The Agreement includes extensive care coordination requirements that conflict with the existing Medicare requirements for a plan's Model of Care are included in the Agreement. Specifically, the ten (10) day timeframe to develop Individualized Care Plans (ICPs) for members after completion of the Health Risk Assessment (HRA) is insufficient.
Rate dispute process	The Agreement excludes rates from the dispute process. Requiring participating plans to waive their legal rights to dispute a rate that may be unreasonable or actuarially unsound is particularly problematic in year 2 and 3 of the demonstration.
Quality withholds	There is a lack of specific information on the quality withhold metrics, and how plans will be measured for purposes of earning back the withheld amount based on performance. The agreement lacks a process for plans to provide meaningful input on the performance metrics that will be tied to the quality withholds for each Demonstration year.
IHSS	Plans are required to assume full risk for IHSS provider payments (i.e., wages and benefits, such as health insurance). The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December. CalOptima Board of Directors would likely have to make a "go / no-go" decision on the 3-way contract for Cal MediConnect in December without the opportunity to review the CDSS contract.
After-hours call capacity	Plans cannot leverage current 24-hour Nurse Advice Lines to meet the after-hours call capacity requirement as the after-hours call service needs to be staffed either by a physician or an appropriate licensed professional under his or her supervision.

Requirement / Area of Concern	Impact
Pending contracts and regulatory guidance	The Agreement incorporates requirements to comply with unissued CMS/DHCS guidance. These references in the Agreement are broad and are not limited to indicating that the guidance will do no more than interpret current requirements under State and Federal laws.
Advisory Committee	Requires the formation of a new Advisory Committee to the Board of Directors, which must consist of not more than eleven (11) people, and no less than fifty percent (50%) of the membership of the advisory committee shall be individuals who are users of personal assistance paid for through public or private funds or recipients of IHSS services.

Other issues related to the Three-Way Agreement for Cal MediConnect include:

- Lack of specific information on IHSS;
  - Data sharing issues with the California Department of Social Services (CDSS) for IHSS; and
  - Contract terms for agreement with CDSS. The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December.

- Reporting requirements not yet specified (e.g., network adequacy, performance measures).

Revisions to CalOptima's FY 2013-14 Implementation, Operating, and Capital Budgets
Staff is submitting revisions to the FY 2013-14 Implementation, Operating, and Capital Budget to the BOD for approval with assumptions based on currently available information.

Proposed Budget 1/1/14 – 6/30/14			
	Implementation	**Operational**	**Total**
Average Monthly Enrollment	N/A	7,118	7,118
Revenue	$0	$43,130,331	$43,130,331
Medical Costs	$2,845,316	$38,414,385	$41,259,701
Administrative Costs	$2,879,267	$4,069,166	$6,948,433
Operating Income/(Loss)	($5,724,583)	$646,780	($5,077,803)
Medical Loss Ratio (MLR)	N/A	89.1%	95.7%
Administrative Loss Ratio (ALR)	N/A	9.4%	16.1%
Capital – Hardware/Software			$1,100,000

Enrollment Assumptions:
- Begins April 1, 2014 with an estimated 3,680 members
- Assumes a pre-enrollment opt-out rate of 20% and disenrollment rate of 5%

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- CY 2014 enrollment will consist of FFS Medicare membership, since Medicare Advantage enrollees are allowed to stay with existing plan through Dec 2014

Revenue Assumptions:
- Bases Medicare rates on draft rates provided in October 2013
- Bases Medi-Cal rates on draft rates provided on November 20, 2013
- Estimates total revenue of $2,019.74 per member per month
- Medicare Part A/B and Part D rates utilizes a base rate and applies a risk adjustment factor (similar to OneCare revenue)
- Medi-Cal rate is a blended rate of four population cohorts: LTC, HCBS High, HCBS Low, and Community Well
- Adjusts rates for savings targets that escalate from 1.4% to 5.5% over the next three and a half years

Medical Cost Assumptions:
- Assumes an average provider capitation rate of 37.5% of Medicare Part A/B premium
- Uses current OneCare medical utilization and unit cost rates as a proxy
- Assumes an MLR of 85.3% on prescription drug benefits
- Assumes an MLR of 90.3% on Medi-Cal wrap-around benefits
- Excludes supplemental benefits with the exception of mental health and transportation services
- Includes program guidelines that require higher levels of Case Management and Health Services
- Estimates eighty-two (82) FTE's are scheduled over the remainder of the year

Administrative Cost Assumptions:
- Includes implementation costs of $5.7 million to prepare the organizations processes, policies, and staff for a targeted go-live date of April 1, 2014
- Program guidelines specify staffing requirements, such as Compliance and Customer Service
- Estimates sixty-three (63) FTE's are scheduled over the remainder of the year
- First twelve (12) months of the program will require higher than standard level of cost for initial items such as member and provider mailings as well as staff recruitment and training. These costs are staged in to occur approximately three (3) months prior to the member enrollment.

Capital Assumptions:
- Includes hardware and software required to support the increase in staffing and projected membership population

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
CCMS (Medical Database)	$ 222,300	20%
Facets Upgrades	204,300	19%
Backup Environment	67,240	6%
Core Infrastructure	58,020	5%
Data Warehouse	43,000	4%

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Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
Misc (Network Costs)	505,140	46%
Total	$ 1,100,000	100%

The Proposed budget includes hardware, software, and professional fees.

Next Steps:
After receipt and review of the Three-Way Agreement and analysis of the interim final rates, Staff recommends the BOD to authorize the Chairman to execute the Three-Way Agreement for CalOptima to participate in Cal MediConnect.

Concurrently, Staff will continue to prepare for the implementation of Cal MediConnect and Managed MLTSS.

Approval of the proposed actions and the Board Chair's execution of the three-way agreement with CMS and DHCS will commit CalOptima to participating in the Cal MediConnect Program.

Fiscal Impact
As outlined above, the proposed revisions to the CalOptima FY 2013-14 Implementation and Operating Budget reflect a deficit of $5.1 million and a Capital Budget of $1.1 million.

Rationale for Recommendation
The DHCS proposal to implement the CCI aligns with CalOptima's long standing commitment to better integrate acute and long term care services. This integration initiative provides CalOptima an opportunity to work with community stakeholders to design a system that fully integrates the administrative and financial responsibilities for Medi-Cal and Medicare covered services and achieve its acute and long term care integration goals.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *11/27/2013*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

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policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

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Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

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Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

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APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

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Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

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- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: January 8, 2019

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer R. Shapiro, Acting Director, Medicare Plan Payment Group

SUBJECT: **Release of 2019 MIPS Payment Adjustment Data File**

The Centers for Medicare & Medicaid Services (CMS) has uploaded to the Health Plan Management System (HPMS) the Merit-based Incentive Payment System (MIPS) Payment Adjustment Data File for payment year 2019. Medicare Advantage organizations (MAOs) can use the information in the file to determine the amount of the MIPS payment adjustment that applies to their payments for Medicare Part B covered professional services furnished by out-of-network MIPS eligible clinicians.

For guidance on when and how the MIPS payments apply to MAOs' payments to MIPS eligible clinicians, please see the April 27, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments" and the November 8, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance."

File Access

The 2019 MIPS Payment Adjustment Data File has been added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). After navigating to the "Incentive Payments" section, a user may download the file by selecting "MIPS Payment Adjustment Data File" under Step One, "2019" under Step Two, and "Download" under Step Three.

Due to the sensitivity of some of the information provided in the file, only the MAO's Medicare Compliance Officer will be able to access and download it. The Compliance Officer must be a registered HPMS user in order to obtain the file.

Identifying the Applicable MIPS Adjustment Percentage

The MIPS Payment Adjustment Data File consists of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)

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- MIPS adjustment percentage
- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see the attached Appendix.

An MAO can identify the applicable MIPS adjustment percentage for a MIPS eligible clinician by matching the clinician's billing TIN/NPI combination to a TIN/NPI combination in the MIPS Payment Adjustment Data File. If an exact match for the billing TIN/NPI combination does not appear in the data file, the MAO should determine whether the NPI appears in combination with another TIN and, if so, apply the MIPS adjustment percentage associated with that TIN/NPI combination. If the NPI appears in more than one TIN/NPI combination in the data file, the MAO should apply the MIPS adjustment percentage for the TIN/NPI combination that results in the greatest total payment amount.

Additional Information

If you encounter technical difficulties when downloading the MIPS Payment Adjustment Data File from HPMS, you may contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028.

If the "Incentive Payments" hyperlink does not appear in the HPMS Data Extract Facility, you must send a request for additional access to hpms_access@cms.hhs.gov. Please note that information in the MIPS Payment Adjustment Data File is considered sensitive and may require additional levels of approval.

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

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Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

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APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

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Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

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policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

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Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

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Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

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APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, except those associated with AltaMed Health Services Corporation, to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

Contact

Michelle Laughlin, Executive Director, Network Operations (714) 246-8400
Nancy Huang, Interim Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the OneCare Connect:

1. Health Network contracts with AMVI Care Health Network, ARTA Western California, Inc., Talbert Medical Group, P.C., Family Choice Medical Group Inc., Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network Inc., Monarch HealthCare, A Medical Group Inc., Orange County Physicians IPA Medical Group Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Prospect Health Plan Inc., and United Care Medical Group, Inc. to:
    i. Extend the OneCare Connect Health Network contract through and including December 31, 2020;
    ii. Add any necessary language provisions required based on the Three-Way Cal MediConnect contract (Three-Way Agreement) between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements, including language reflecting changes related to the Merit-based Incentive Payments System (MIPS) program;
    iii. Clarify access standards for prenatal care; and
2. Physician Hospital Consortium capitated Hospital contract with Fountain Valley Regional Hospital and Medical Center, and OneCare Connect Full-Risk Health Network contracts with Heritage Provider Network Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to incorporate the retrospective non-contracted Ground Emergency Medical Transport (GEMT) provider rate increase requirements for the July 1, 2018 through June 30, 2019 and the July 1, 2019 through June 30, 2020 periods, and the additional compensation to these Health Networks for such services.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (CMC) OneCare Connect beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

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Cal MediConnect was launched in 2014 as a three-year demonstration program implemented across eight counties. OneCare Connect (OCC) was launched July 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated Health Networks to manage services to the network's assigned membership.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019. At its November 2018 meeting, the Board authorized CalOptima to extend the Health Network contracts for one year through December 31, 2019.
At its October 3, 2019 meeting, the Board authorized execution of the newest version of the three-way agreement, which became effective September 1, 2019. Among the key changes of the new agreement was extension of the Cal MediConnect demonstration period through, December 31, 2022, in one-year terms. In accordance with this change, staff is seeking authorization to extend the Health Network agreements for an additional year through December 31, 2020.

Discussion

Language Provisions; Agreement with CMS and DHCS

Contract amendments will be required to include provisions to address technical revisions and any other new/revised requirements from the new Three-Way Agreement that are applicable to the OneCare Connect Health Networks. To be in compliance with the most current version of the Three-Way Agreement received from DHCS, effective September 1, 2019, staff seeks authority to amend OneCare Connect Health Network contracts to ensure contracted OCC Health Networks ensure that providers are enrolled with DHCS as Medicaid providers consistent with all Medicaid enrollment requirements. Other changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Merit-based Incentive Payment Systems (MIPS)

In accordance with the Medicare Access and CHIP Reauthorization Act of 2015 Quality Payment Program memorandum and CalOptima Policies and Procedures, Health Networks implemented the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. This provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Payment to health networks is contingent upon annual receipt of their provider payment adjustment confirmation report, which identifies and reports all claims qualifying for MIPS payment adjustments. Health Networks are required to submit their adjustment reports on an annual basis, starting July 2020. For dates of service January 1, 2019 through December 31, 2019, payment year is 2021. Staff seeks authority to amend contracts to include language in support of the MIPS payment adjustments to the OCC Health Networks to remain in compliance with this CMS-mandated program.

Access Standards for Prenatal Care

As it relates to maternity services and access standards for prenatal care, the OneCare Connect Contract will be updated to be consistent with CalOptima's Medi-Cal Health Network contracts. The Medi-Cal Health Network contract language ensures that the most current standards or guidelines of the American

College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for prenatal services and ensure that Physician Groups have a process in place for follow-up on Member missed appointments.

Ground Emergency Medical Transport (GEMT)

Through the DHCS-established Quality Assurance Fee (QAF) program, retrospective payments to non-contracted Ground Emergency Medical Transport providers have been approved for the State Fiscal Years (SFY) 2018-2019 and 2019-2020, up to $400 per identified service. The program has been designated as a Medi-Cal benefit, requiring CalOptima to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support, Emergency), A0427 (Advanced Life Support, Level 1, Emergency), A0433 (Advanced Life Support, Level 2), A0434 (Specialty Care Transport), and A0225 (Neonatal Emergency Transport). Reimbursement of the difference between the base Medi-Cal rate for eligible services and the increase up to $400 is applicable toward the Physician Hospital Consortia capitated Hospital and Full-Risk Health Network contracts. Payments will be contingent on receipt of the GEMT payment adjustment confirmation report required from the health networks. Reimbursement payments will be made only in cases where the new Medi-Cal rate exceeds the Out-of-Network Medicare allowable reimbursement rate. These amendments will be renewed each year that GEMT provisions are extended past SFY 2019-2020.

Summary of Recommendations

Staff seeks Board authorization to amend the Health Network agreements as needed to extend and add any necessary language provisions required by the Three-Way Agreement, and to include language supporting the provision for MIPS, ACOG and GEMT.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect Health Network capitation expenses of $131 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The recommended action to renew the existing Health Network contracts through June 30, 2020, is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extensions, in the CalOptima FY 2020-21 Operating Budget.

The recommended action to amend the OneCare Connect Physician Hospital Consortium capitated hospital contract and OneCare Connect Full-Risk Health Network contracts to incorporate the retrospective non-contracted GEMT provider rate increase requirements for SFY 2018-19 is budget neutral. Funding for non-contracted GEMT provider payments for OneCare Connect was not included in the CalOptima FY 2019-20 Operating Budget approved by the Board on June 6, 2019. To date, staff has not received the most updated rates from DHCS. However, revenue from the State is anticipated to be sufficient to cover the estimated costs.

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OCC members is maintained, allows flexibility to modify OCC Health Network contracts as needed based on CalOptima's Three-Way Agreement with DHCS and CMS, support CalOptima's payment obligations under the MIPS program, ensure access standards for prenatal care are aligned with the most current ACOG standards and guidelines, and Physician Health Consortium capitated Hospital and Full-Risk Health Network contracts support GEMT payments through the end of Fiscal year 2019-2020.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated December 5, 2013; Consider Participation in the Cal MediConnect Program
3. Board Action dated September 7, 2017; Authorize and Direct Execution of a New Three-Way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program
4. Board Action dated November 1, 2018; Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts
5. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
6. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
7. CMS Release of 2019 MIPS Payment Adjustment Data File
8. Board Action dated September 5, 2019; Consider Actions Related to Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services
9. California State Plan Amendment 19-0020

/s/ Michael Schrader *10/30/2019*

Authorized Signature **Date**

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AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
ARTA Western California, Inc.	1665 Scenic Ave Dr, Suite 100	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
Talbert Medical Group, P.C.	1665 Scenic Avenue, Suite 100	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. C. Consider Participation in the Cal MediConnect Program

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400
Patti McFarland, Chief Financial Officer, (714) 246-8400

Recommended Actions
Consider the following required actions to participate in the Cal MediConnect Program:
1. Authorize and Direct the Chairman of the Board of Directors to Execute the Three-Way Agreement between the California DHCS, CMS and CalOptima for Cal MediConnect, subject to the interim final rates that will not harm the financial viability of CalOptima and reasonable and expected requirements related to operations and reporting;
2. Authorize and Direct the Chairman of the Board of Directors to Execute the California Department of Social Services' (CDSS) Contract for In-Home Supportive Services (IHSS);
3. Approve Revisions Related to Cal MediConnect to CalOptima's Fiscal Year (FY) 2013-14 Budget; and
4. Authorize the CEO to develop and/or update policies necessary to meet Cal MediConnect participation requirements and implement the program's benefit set.

Background
In June 2012, Senate Bill 1008 (2012) and SB 1036 (2012) authorized the Coordinated Care Initiative (CCI). The CCI is composed of two (2) key components that will work in tandem to improve care coordination and integration.

1. Cal MediConnect: No sooner than April 1, 2014, the state will begin a three (3) year federal-state demonstration program in eight (8) counties. Individuals with Medicare and Medi-Cal (i.e., dual eligible beneficiaries) will receive coordinated medical, behavioral health, institutional long-term care, and home and community based services through a single Medi-Cal managed care plan. The participating counties are: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside, and San Bernardino.

2. Managed Medi-Cal Long-Term Supports and Services (MLTSS): No sooner than April 1, 2014, all Medi-Cal beneficiaries, including dual eligible beneficiaries, will receive long-term services and supports and Medi-Cal wrap-around benefits through a Medi-Cal managed care plan. MLTSS includes institutional long-term care, Community Based Adult Services, Multipurpose Senior Services Program, and IHSS.

   As a County Organized Health System (COHS), CalOptima already serves dual eligible beneficiaries, and provides Medi-Cal wrap-around services to members. In addition, pursuant to SB 94 (2013), DHCS separated the MLTSS component from the Cal MediConnect program. Medi-Cal managed care plans will provide MLTSS as a Medi-Cal benefit to all enrollees even if Cal Medi-Connect does not move forward.

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DHCS initially proposed to implement Cal MediConnect no sooner than January 1, 2014. However, DHCS revised the timeline several times to accommodate ongoing negotiations with CMS and to resolve other implementation issues. On August 13, 2013, DHCS formally announced that Cal MediConnect will begin no sooner than April 1, 2014. Initial enrollment will occur on a passive enrollment basis for a twelve (12) month period, based on the eligible beneficiary's birthday month.

CalOptima's FY 2013-14 Operating Budget projected an increased enrollment of 27,000 members from the Cal MediConnect program through June 30, 2014. Staff will make a downward adjustment to the membership projection due to the delayed implementation date, and anticipates approximately 3,700 members will be passively enrolled each month. Staff will implement strategies to minimize the opt-out rate of the Cal MediConnect program.

The Demonstration Years for the Cal MediConnect program are as follows:

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

On May 3, 2012, your Board approved a pre-implementation budget for the CCI of $373,994 to proceed with the application process to participate in the program. The funds were used to support travel and training, consultant fees, limited term staffing, and outreach and engagement. The budget was for the period of May 3, 2012, through August 31, 2012.

On January 3, 2013, your Board approved additional funding to continue pre-implementation planning for the CCI of $615,000 for a total of $988,994. The funds were used to support professional fees and staffing. To date, approximately ninety-five percent (95%) of the pre-implementation funds have been spent. Based on Board approval, staff has completed all state and federal applications and additional requests, including but not limited to:

Key Deliverables	Date
DHCS Request for Solutions	February 23, 2012
CMS Capitated Financial Alignment Demonstration application	May 23, 2012
Proposed Model of Care	June 29, 2012
Proposed Medication Management Therapy Program	May 6, 2013
Proposed Part D Formulary	May 31, 2013
Proposed Plan Benefit Package	June 3, 2013
Revised Health Service Delivery Tables for Network Validation	June 26, 2013

Key steps and milestones for the Cal MediConnect program are as follows:

Key Steps and Milestones	Date
Finalize Memorandum of Understanding (MOU) (CMS and DHCS)	Executed March 27, 2013

Key Steps and Milestones	Date
Develop final capitation rates	Ongoing since April 23, 2013
Conduct joint readiness assessments (CMS and DHCS)	Initiated March 2013 and ongoing through December 2013 - Desk Review: April 19, 2013 - On-site visit: July 25-26, 2013 - Remote Systems Testing: October 21, 2013 - Network Validation: October 28, 2013 - Pre-Enrollment Validation: November 20, 2013 - Final Readiness report to be issued mid-December 2013
Execute MOUs with relevant county agencies	Completed in July and August 2013
Sign Three-Way contract	December 13, 2013 (electronic signature) December 16, 2013 (hard copy signature)
Sign CDSS contract for IHSS services	Mid-December 2013 (anticipated)
Finalize Plan Benefit Package in CMS system	Mid-December 2013
Implement Cal MediConnect	No sooner than April 1, 2014

On June 6, 2013, your Board approved CalOptima's FY 2013-14 Operating Budget. Staff clarified that the operating budget did not include infrastructure and implementation funding for the Duals Demonstration (i.e., the Cal MediConnect program), and that Staff would present the budget as a separate Board action.

Discussion

Both DHCS and CMS are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of Cal MediConnect. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted, as noted above, from the prior dates shared with the Board in previous meetings. Staff participated in the on-site readiness review July 25-26, 2013.

The next key step is for CalOptima to sign the Three-Way Agreement with CMS and DHCS. Recently, DHCS notified participating plans that the final date by which CMS will require execution of the Agreement is December 10, 2013. Plans, including CalOptima, received the "final" Three-Way Agreement on November 6, 2013 and were advised that they would not be able to negotiate changes to the Agreement. Although the document contains a number of terms that are currently in other program agreements, this was the first time that plans received the document which contains new Cal MediConnect program requirements, Plans had approximately one week to review the document and submit a list of "significant concerns" to the Agreement. DHCS held a conference call with plans on November 20, 2013 to discuss the comments plans submitted. On the call, the DHCS provided clarification on certain terms, but essentially reiterated that the "final" version was, in fact, final. CMS and DHCS issued interim final rates in late October for plans' thirty (30) day review. Additionally, DHCS has indicated that rates may be subject to additional minor revisions prior to the final execution of the Agreement.

Three-Way Cal MediConnect Agreement

The Agreement between DHCS, CMS, and CalOptima outlines the respective obligations for each party to implement the Cal MediConnect program in Orange County. The Agreement contains provisions for CMS

and DHCS to evaluate CalOptima's performance as a Cal MediConnect participating plan, including adherence to federal Medicare and Medicaid laws.

Below are some areas within the Agreement that will have a significant operational and financial impact:

Requirement / Area of Concern	Impact
Benefits and funding streams	The Agreement reflects continued fragmentation of Medicare and Medi-Cal benefits, services, and funding streams will pose operational challenges. Full integration will likely not occur until year 2 of the demonstration.
Care coordination	The Agreement includes extensive care coordination requirements that conflict with the existing Medicare requirements for a plan's Model of Care are included in the Agreement. Specifically, the ten (10) day timeframe to develop Individualized Care Plans (ICPs) for members after completion of the Health Risk Assessment (HRA) is insufficient.
Rate dispute process	The Agreement excludes rates from the dispute process. Requiring participating plans to waive their legal rights to dispute a rate that may be unreasonable or actuarially unsound is particularly problematic in year 2 and 3 of the demonstration.
Quality withholds	There is a lack of specific information on the quality withhold metrics, and how plans will be measured for purposes of earning back the withheld amount based on performance. The agreement lacks a process for plans to provide meaningful input on the performance metrics that will be tied to the quality withholds for each Demonstration year.
IHSS	Plans are required to assume full risk for IHSS provider payments (i.e., wages and benefits, such as health insurance). The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December. CalOptima Board of Directors would likely have to make a "go / no-go" decision on the 3-way contract for Cal MediConnect in December without the opportunity to review the CDSS contract.
After-hours call capacity	Plans cannot leverage current 24-hour Nurse Advice Lines to meet the after-hours call capacity requirement as the after-hours call service needs to be staffed either by a physician or an appropriate licensed professional under his or her supervision.

Requirement / Area of Concern	Impact
Pending contracts and regulatory guidance	The Agreement incorporates requirements to comply with unissued CMS/DHCS guidance. These references in the Agreement are broad and are not limited to indicating that the guidance will do no more than interpret current requirements under State and Federal laws.
Advisory Committee	Requires the formation of a new Advisory Committee to the Board of Directors, which must consist of not more than eleven (11) people, and no less than fifty percent (50%) of the membership of the advisory committee shall be individuals who are users of personal assistance paid for through public or private funds or recipients of IHSS services.

Other issues related to the Three-Way Agreement for Cal MediConnect include:

- Lack of specific information on IHSS;
  - Data sharing issues with the California Department of Social Services (CDSS) for IHSS; and
  - Contract terms for agreement with CDSS. The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December.

- Reporting requirements not yet specified (e.g., network adequacy, performance measures).

Revisions to CalOptima's FY 2013-14 Implementation, Operating, and Capital Budgets
Staff is submitting revisions to the FY 2013-14 Implementation, Operating, and Capital Budget to the BOD for approval with assumptions based on currently available information.

Proposed Budget 1/1/14 – 6/30/14			
	Implementation	**Operational**	**Total**
Average Monthly Enrollment	N/A	7,118	7,118
Revenue	$0	$43,130,331	$43,130,331
Medical Costs	$2,845,316	$38,414,385	$41,259,701
Administrative Costs	$2,879,267	$4,069,166	$6,948,433
Operating Income/(Loss)	($5,724,583)	$646,780	($5,077,803)
Medical Loss Ratio (MLR)	N/A	89.1%	95.7%
Administrative Loss Ratio (ALR)	N/A	9.4%	16.1%
Capital – Hardware/Software			$1,100,000

Enrollment Assumptions:
- Begins April 1, 2014 with an estimated 3,680 members
- Assumes a pre-enrollment opt-out rate of 20% and disenrollment rate of 5%

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- CY 2014 enrollment will consist of FFS Medicare membership, since Medicare Advantage enrollees are allowed to stay with existing plan through Dec 2014

Revenue Assumptions:
- Bases Medicare rates on draft rates provided in October 2013
- Bases Medi-Cal rates on draft rates provided on November 20, 2013
- Estimates total revenue of $2,019.74 per member per month
- Medicare Part A/B and Part D rates utilizes a base rate and applies a risk adjustment factor (similar to OneCare revenue)
- Medi-Cal rate is a blended rate of four population cohorts: LTC, HCBS High, HCBS Low, and Community Well
- Adjusts rates for savings targets that escalate from 1.4% to 5.5% over the next three and a half years

Medical Cost Assumptions:
- Assumes an average provider capitation rate of 37.5% of Medicare Part A/B premium
- Uses current OneCare medical utilization and unit cost rates as a proxy
- Assumes an MLR of 85.3% on prescription drug benefits
- Assumes an MLR of 90.3% on Medi-Cal wrap-around benefits
- Excludes supplemental benefits with the exception of mental health and transportation services
- Includes program guidelines that require higher levels of Case Management and Health Services
- Estimates eighty-two (82) FTE's are scheduled over the remainder of the year

Administrative Cost Assumptions:
- Includes implementation costs of $5.7 million to prepare the organizations processes, policies, and staff for a targeted go-live date of April 1, 2014
- Program guidelines specify staffing requirements, such as Compliance and Customer Service
- Estimates sixty-three (63) FTE's are scheduled over the remainder of the year
- First twelve (12) months of the program will require higher than standard level of cost for initial items such as member and provider mailings as well as staff recruitment and training. These costs are staged in to occur approximately three (3) months prior to the member enrollment.

Capital Assumptions:
- Includes hardware and software required to support the increase in staffing and projected membership population

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
CCMS (Medical Database)	$ 222,300	20%
Facets Upgrades	204,300	19%
Backup Environment	67,240	6%
Core Infrastructure	58,020	5%
Data Warehouse	43,000	4%

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Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
Misc (Network Costs)	505,140	46%
Total	$ 1,100,000	100%

The Proposed budget includes hardware, software, and professional fees.

Next Steps:
After receipt and review of the Three-Way Agreement and analysis of the interim final rates, Staff recommends the BOD to authorize the Chairman to execute the Three-Way Agreement for CalOptima to participate in Cal MediConnect.

Concurrently, Staff will continue to prepare for the implementation of Cal MediConnect and Managed MLTSS.

Approval of the proposed actions and the Board Chair's execution of the three-way agreement with CMS and DHCS will commit CalOptima to participating in the Cal MediConnect Program.

Fiscal Impact
As outlined above, the proposed revisions to the CalOptima FY 2013-14 Implementation and Operating Budget reflect a deficit of $5.1 million and a Capital Budget of $1.1 million.

Rationale for Recommendation
The DHCS proposal to implement the CCI aligns with CalOptima's long standing commitment to better integrate acute and long term care services. This integration initiative provides CalOptima an opportunity to work with community stakeholders to design a system that fully integrates the administrative and financial responsibilities for Medi-Cal and Medicare covered services and achieve its acute and long term care integration goals.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *11/27/2013*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

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policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

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Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

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Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

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APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

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Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

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- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: January 8, 2019

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer R. Shapiro, Acting Director, Medicare Plan Payment Group

SUBJECT: **Release of 2019 MIPS Payment Adjustment Data File**

The Centers for Medicare & Medicaid Services (CMS) has uploaded to the Health Plan Management System (HPMS) the Merit-based Incentive Payment System (MIPS) Payment Adjustment Data File for payment year 2019. Medicare Advantage organizations (MAOs) can use the information in the file to determine the amount of the MIPS payment adjustment that applies to their payments for Medicare Part B covered professional services furnished by out-of-network MIPS eligible clinicians.

For guidance on when and how the MIPS payments apply to MAOs' payments to MIPS eligible clinicians, please see the April 27, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments" and the November 8, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance."

File Access

The 2019 MIPS Payment Adjustment Data File has been added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). After navigating to the "Incentive Payments" section, a user may download the file by selecting "MIPS Payment Adjustment Data File" under Step One, "2019" under Step Two, and "Download" under Step Three.

Due to the sensitivity of some of the information provided in the file, only the MAO's Medicare Compliance Officer will be able to access and download it. The Compliance Officer must be a registered HPMS user in order to obtain the file.

Identifying the Applicable MIPS Adjustment Percentage

The MIPS Payment Adjustment Data File consists of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)

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- MIPS adjustment percentage
- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see the attached Appendix.

An MAO can identify the applicable MIPS adjustment percentage for a MIPS eligible clinician by matching the clinician's billing TIN/NPI combination to a TIN/NPI combination in the MIPS Payment Adjustment Data File. If an exact match for the billing TIN/NPI combination does not appear in the data file, the MAO should determine whether the NPI appears in combination with another TIN and, if so, apply the MIPS adjustment percentage associated with that TIN/NPI combination. If the NPI appears in more than one TIN/NPI combination in the data file, the MAO should apply the MIPS adjustment percentage for the TIN/NPI combination that results in the greatest total payment amount.

Additional Information

If you encounter technical difficulties when downloading the MIPS Payment Adjustment Data File from HPMS, you may contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028.

If the "Incentive Payments" hyperlink does not appear in the HPMS Data Extract Facility, you must send a request for additional access to hpms_access@cms.hhs.gov. Please note that information in the MIPS Payment Adjustment Data File is considered sensitive and may require additional levels of approval.

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

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increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

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Attachment to the September 5, 2019 Board of Directors Meeting – Agenda Item 9

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Regional Operations Group

September 6, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 19-0020, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 30, 2019. SPA 19-0020 continues the Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers to Medi-Cal patients from July 1, 2019 to June 30, 2020.

The effective date of this SPA is July 1, 2019. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard C. Allen
Director
Western Regional Operations Group

cc: Jacey Cooper, California Department of Health Care Services (DHCS)
Lindy Harrington, DHCS
Connie Florez, DHCS
Michelle Tamai, DHCS
Adam Neighbours, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 19 — 00 20

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: Title 42 CFR 447 Subpart F

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ 2019 $ $4,809,054
b. FFY ~~2019~~ 2020 $ $14,427,163

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 29, Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Supplement 29, Attachment 4.19-B, pages 1-2

10. SUBJECT OF AMENDMENT

One-year reimbursement rate add-on for ground emergency medical transports with dates of service between July 1, 2019 and June 30, 2020.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME: Mari Cantwell

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: July 30, 2019

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: July 30, 2019

18. DATE APPROVED: September 6, 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME: Richard C. Allen

22. TITLE: Director, Center for Medicaid & CHIP Services, Regional Operations Group

23. REMARKS

For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.

Box 7: CMS pen and ink change to update years per state response to informal questions dated 8/21/19.

FORM CMS-179 (07/92)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, as described below, effective July 1, 2018 through June 30, 2019 and July 1, 2019 through June 30, 2020. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429 BLS Emergency, A0427 ALS Emergency, A0433 ALS2, A0434 Specialty Care Transport, and A0225 Neonatal Emergency Transport. An "emergency medical transport" does not occur when, following evaluation of a patient, a transport is not provided.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for SFY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 is $339.00. The add-on is paid on a per-claim basis.

For SFY 2019-20, the reimbursement rate add-on is fixed. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, A0433, and A0434 is $339.00, and for CPT Code A0225 is $400.72. The add-on is paid for each eligible CPT Code on a per-claim basis.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

Service Code	Description	Current Payment*	Add On Amount	Resulting Total Payment
A0429	Basic Life Support, Emergency	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00
A0434	Specialty Care Transport	$118.20	$220.80	$339.00
A0225	Neonatal Emergency Transport	$179.92	$220.80	$400.72

*These are the base rates associated with these codes, but are subject to further adjustments pursuant to the State Plan.

The resulting total payment amount as listed in the table above for the applicable CPT Code is considered the Rogers rate, which managed care organizations shall pay noncontract managed care emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code, for each state fiscal year the FFS reimbursement rate add-on is effective.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, except those associated with AltaMed Health Services Corporation, to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

Contact

Michelle Laughlin, Executive Director, Network Operations (714) 246-8400
Nancy Huang, Interim Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the OneCare Connect:

1. Health Network contracts with AMVI Care Health Network, ARTA Western California, Inc., Talbert Medical Group, P.C., Family Choice Medical Group Inc., Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network Inc., Monarch HealthCare, A Medical Group Inc., Orange County Physicians IPA Medical Group Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Prospect Health Plan Inc., and United Care Medical Group, Inc. to:
    i. Extend the OneCare Connect Health Network contract through and including December 31, 2020;
    ii. Add any necessary language provisions required based on the Three-Way Cal MediConnect contract (Three-Way Agreement) between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements, including language reflecting changes related to the Merit-based Incentive Payments System (MIPS) program;
    iii. Clarify access standards for prenatal care; and
2. Physician Hospital Consortium capitated Hospital contract with Fountain Valley Regional Hospital and Medical Center, and OneCare Connect Full-Risk Health Network contracts with Heritage Provider Network Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to incorporate the retrospective non-contracted Ground Emergency Medical Transport (GEMT) provider rate increase requirements for the July 1, 2018 through June 30, 2019 and the July 1, 2019 through June 30, 2020 periods, and the additional compensation to these Health Networks for such services.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (CMC) OneCare Connect beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

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Cal MediConnect was launched in 2014 as a three-year demonstration program implemented across eight counties. OneCare Connect (OCC) was launched July 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated Health Networks to manage services to the network's assigned membership.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019. At its November 2018 meeting, the Board authorized CalOptima to extend the Health Network contracts for one year through December 31, 2019.
At its October 3, 2019 meeting, the Board authorized execution of the newest version of the three-way agreement, which became effective September 1, 2019. Among the key changes of the new agreement was extension of the Cal MediConnect demonstration period through, December 31, 2022, in one-year terms. In accordance with this change, staff is seeking authorization to extend the Health Network agreements for an additional year through December 31, 2020.

Discussion

Language Provisions; Agreement with CMS and DHCS

Contract amendments will be required to include provisions to address technical revisions and any other new/revised requirements from the new Three-Way Agreement that are applicable to the OneCare Connect Health Networks. To be in compliance with the most current version of the Three-Way Agreement received from DHCS, effective September 1, 2019, staff seeks authority to amend OneCare Connect Health Network contracts to ensure contracted OCC Health Networks ensure that providers are enrolled with DHCS as Medicaid providers consistent with all Medicaid enrollment requirements. Other changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Merit-based Incentive Payment Systems (MIPS)

In accordance with the Medicare Access and CHIP Reauthorization Act of 2015 Quality Payment Program memorandum and CalOptima Policies and Procedures, Health Networks implemented the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. This provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Payment to health networks is contingent upon annual receipt of their provider payment adjustment confirmation report, which identifies and reports all claims qualifying for MIPS payment adjustments. Health Networks are required to submit their adjustment reports on an annual basis, starting July 2020. For dates of service January 1, 2019 through December 31, 2019, payment year is 2021. Staff seeks authority to amend contracts to include language in support of the MIPS payment adjustments to the OCC Health Networks to remain in compliance with this CMS-mandated program.

Access Standards for Prenatal Care

As it relates to maternity services and access standards for prenatal care, the OneCare Connect Contract will be updated to be consistent with CalOptima's Medi-Cal Health Network contracts. The Medi-Cal Health Network contract language ensures that the most current standards or guidelines of the American

College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for prenatal services and ensure that Physician Groups have a process in place for follow-up on Member missed appointments.

Ground Emergency Medical Transport (GEMT)

Through the DHCS-established Quality Assurance Fee (QAF) program, retrospective payments to non-contracted Ground Emergency Medical Transport providers have been approved for the State Fiscal Years (SFY) 2018-2019 and 2019-2020, up to $400 per identified service. The program has been designated as a Medi-Cal benefit, requiring CalOptima to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support, Emergency), A0427 (Advanced Life Support, Level 1, Emergency), A0433 (Advanced Life Support, Level 2), A0434 (Specialty Care Transport), and A0225 (Neonatal Emergency Transport). Reimbursement of the difference between the base Medi-Cal rate for eligible services and the increase up to $400 is applicable toward the Physician Hospital Consortia capitated Hospital and Full-Risk Health Network contracts. Payments will be contingent on receipt of the GEMT payment adjustment confirmation report required from the health networks. Reimbursement payments will be made only in cases where the new Medi-Cal rate exceeds the Out-of-Network Medicare allowable reimbursement rate. These amendments will be renewed each year that GEMT provisions are extended past SFY 2019-2020.

Summary of Recommendations

Staff seeks Board authorization to amend the Health Network agreements as needed to extend and add any necessary language provisions required by the Three-Way Agreement, and to include language supporting the provision for MIPS, ACOG and GEMT.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect Health Network capitation expenses of $131 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The recommended action to renew the existing Health Network contracts through June 30, 2020, is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extensions, in the CalOptima FY 2020-21 Operating Budget.

The recommended action to amend the OneCare Connect Physician Hospital Consortium capitated hospital contract and OneCare Connect Full-Risk Health Network contracts to incorporate the retrospective non-contracted GEMT provider rate increase requirements for SFY 2018-19 is budget neutral. Funding for non-contracted GEMT provider payments for OneCare Connect was not included in the CalOptima FY 2019-20 Operating Budget approved by the Board on June 6, 2019. To date, staff has not received the most updated rates from DHCS. However, revenue from the State is anticipated to be sufficient to cover the estimated costs.

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OCC members is maintained, allows flexibility to modify OCC Health Network contracts as needed based on CalOptima's Three-Way Agreement with DHCS and CMS, support CalOptima's payment obligations under the MIPS program, ensure access standards for prenatal care are aligned with the most current ACOG standards and guidelines, and Physician Health Consortium capitated Hospital and Full-Risk Health Network contracts support GEMT payments through the end of Fiscal year 2019-2020.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated December 5, 2013; Consider Participation in the Cal MediConnect Program
3. Board Action dated September 7, 2017; Authorize and Direct Execution of a New Three-Way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program
4. Board Action dated November 1, 2018; Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts
5. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
6. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
7. CMS Release of 2019 MIPS Payment Adjustment Data File
8. Board Action dated September 5, 2019; Consider Actions Related to Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services
9. California State Plan Amendment 19-0020

/s/ Michael Schrader *10/30/2019*

Authorized Signature **Date**

AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
ARTA Western California, Inc.	1665 Scenic Ave Dr, Suite 100	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
Talbert Medical Group, P.C.	1665 Scenic Avenue, Suite 100	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. C. Consider Participation in the Cal MediConnect Program

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400
Patti McFarland, Chief Financial Officer, (714) 246-8400

Recommended Actions
Consider the following required actions to participate in the Cal MediConnect Program:
1. Authorize and Direct the Chairman of the Board of Directors to Execute the Three-Way Agreement between the California DHCS, CMS and CalOptima for Cal MediConnect, subject to the interim final rates that will not harm the financial viability of CalOptima and reasonable and expected requirements related to operations and reporting;
2. Authorize and Direct the Chairman of the Board of Directors to Execute the California Department of Social Services' (CDSS) Contract for In-Home Supportive Services (IHSS);
3. Approve Revisions Related to Cal MediConnect to CalOptima's Fiscal Year (FY) 2013-14 Budget; and
4. Authorize the CEO to develop and/or update policies necessary to meet Cal MediConnect participation requirements and implement the program's benefit set.

Background
In June 2012, Senate Bill 1008 (2012) and SB 1036 (2012) authorized the Coordinated Care Initiative (CCI). The CCI is composed of two (2) key components that will work in tandem to improve care coordination and integration.

1. Cal MediConnect: No sooner than April 1, 2014, the state will begin a three (3) year federal-state demonstration program in eight (8) counties. Individuals with Medicare and Medi-Cal (i.e., dual eligible beneficiaries) will receive coordinated medical, behavioral health, institutional long-term care, and home and community based services through a single Medi-Cal managed care plan. The participating counties are: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside, and San Bernardino.

2. Managed Medi-Cal Long-Term Supports and Services (MLTSS): No sooner than April 1, 2014, all Medi-Cal beneficiaries, including dual eligible beneficiaries, will receive long-term services and supports and Medi-Cal wrap-around benefits through a Medi-Cal managed care plan. MLTSS includes institutional long-term care, Community Based Adult Services, Multipurpose Senior Services Program, and IHSS.

   As a County Organized Health System (COHS), CalOptima already serves dual eligible beneficiaries, and provides Medi-Cal wrap-around services to members. In addition, pursuant to SB 94 (2013), DHCS separated the MLTSS component from the Cal MediConnect program. Medi-Cal managed care plans will provide MLTSS as a Medi-Cal benefit to all enrollees even if Cal Medi-Connect does not move forward.

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DHCS initially proposed to implement Cal MediConnect no sooner than January 1, 2014. However, DHCS revised the timeline several times to accommodate ongoing negotiations with CMS and to resolve other implementation issues. On August 13, 2013, DHCS formally announced that Cal MediConnect will begin no sooner than April 1, 2014. Initial enrollment will occur on a passive enrollment basis for a twelve (12) month period, based on the eligible beneficiary's birthday month.

CalOptima's FY 2013-14 Operating Budget projected an increased enrollment of 27,000 members from the Cal MediConnect program through June 30, 2014. Staff will make a downward adjustment to the membership projection due to the delayed implementation date, and anticipates approximately 3,700 members will be passively enrolled each month. Staff will implement strategies to minimize the opt-out rate of the Cal MediConnect program.

The Demonstration Years for the Cal MediConnect program are as follows:

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

On May 3, 2012, your Board approved a pre-implementation budget for the CCI of $373,994 to proceed with the application process to participate in the program. The funds were used to support travel and training, consultant fees, limited term staffing, and outreach and engagement. The budget was for the period of May 3, 2012, through August 31, 2012.

On January 3, 2013, your Board approved additional funding to continue pre-implementation planning for the CCI of $615,000 for a total of $988,994. The funds were used to support professional fees and staffing. To date, approximately ninety-five percent (95%) of the pre-implementation funds have been spent. Based on Board approval, staff has completed all state and federal applications and additional requests, including but not limited to:

Key Deliverables	Date
DHCS Request for Solutions	February 23, 2012
CMS Capitated Financial Alignment Demonstration application	May 23, 2012
Proposed Model of Care	June 29, 2012
Proposed Medication Management Therapy Program	May 6, 2013
Proposed Part D Formulary	May 31, 2013
Proposed Plan Benefit Package	June 3, 2013
Revised Health Service Delivery Tables for Network Validation	June 26, 2013

Key steps and milestones for the Cal MediConnect program are as follows:

Key Steps and Milestones	Date
Finalize Memorandum of Understanding (MOU) (CMS and DHCS)	Executed March 27, 2013

Key Steps and Milestones	Date
Develop final capitation rates	Ongoing since April 23, 2013
Conduct joint readiness assessments (CMS and DHCS)	Initiated March 2013 and ongoing through December 2013 - Desk Review: April 19, 2013 - On-site visit: July 25-26, 2013 - Remote Systems Testing: October 21, 2013 - Network Validation: October 28, 2013 - Pre-Enrollment Validation: November 20, 2013 - Final Readiness report to be issued mid-December 2013
Execute MOUs with relevant county agencies	Completed in July and August 2013
Sign Three-Way contract	December 13, 2013 (electronic signature) December 16, 2013 (hard copy signature)
Sign CDSS contract for IHSS services	Mid-December 2013 (anticipated)
Finalize Plan Benefit Package in CMS system	Mid-December 2013
Implement Cal MediConnect	No sooner than April 1, 2014

On June 6, 2013, your Board approved CalOptima's FY 2013-14 Operating Budget. Staff clarified that the operating budget did not include infrastructure and implementation funding for the Duals Demonstration (i.e., the Cal MediConnect program), and that Staff would present the budget as a separate Board action.

Discussion

Both DHCS and CMS are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of Cal MediConnect. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted, as noted above, from the prior dates shared with the Board in previous meetings. Staff participated in the on-site readiness review July 25-26, 2013.

The next key step is for CalOptima to sign the Three-Way Agreement with CMS and DHCS. Recently, DHCS notified participating plans that the final date by which CMS will require execution of the Agreement is December 10, 2013. Plans, including CalOptima, received the "final" Three-Way Agreement on November 6, 2013 and were advised that they would not be able to negotiate changes to the Agreement. Although the document contains a number of terms that are currently in other program agreements, this was the first time that plans received the document which contains new Cal MediConnect program requirements, Plans had approximately one week to review the document and submit a list of "significant concerns" to the Agreement. DHCS held a conference call with plans on November 20, 2013 to discuss the comments plans submitted. On the call, the DHCS provided clarification on certain terms, but essentially reiterated that the "final" version was, in fact, final. CMS and DHCS issued interim final rates in late October for plans' thirty (30) day review. Additionally, DHCS has indicated that rates may be subject to additional minor revisions prior to the final execution of the Agreement.

Three-Way Cal MediConnect Agreement

The Agreement between DHCS, CMS, and CalOptima outlines the respective obligations for each party to implement the Cal MediConnect program in Orange County. The Agreement contains provisions for CMS

and DHCS to evaluate CalOptima's performance as a Cal MediConnect participating plan, including adherence to federal Medicare and Medicaid laws.

Below are some areas within the Agreement that will have a significant operational and financial impact:

Requirement / Area of Concern	Impact
Benefits and funding streams	The Agreement reflects continued fragmentation of Medicare and Medi-Cal benefits, services, and funding streams will pose operational challenges. Full integration will likely not occur until year 2 of the demonstration.
Care coordination	The Agreement includes extensive care coordination requirements that conflict with the existing Medicare requirements for a plan's Model of Care are included in the Agreement. Specifically, the ten (10) day timeframe to develop Individualized Care Plans (ICPs) for members after completion of the Health Risk Assessment (HRA) is insufficient.
Rate dispute process	The Agreement excludes rates from the dispute process. Requiring participating plans to waive their legal rights to dispute a rate that may be unreasonable or actuarially unsound is particularly problematic in year 2 and 3 of the demonstration.
Quality withholds	There is a lack of specific information on the quality withhold metrics, and how plans will be measured for purposes of earning back the withheld amount based on performance. The agreement lacks a process for plans to provide meaningful input on the performance metrics that will be tied to the quality withholds for each Demonstration year.
IHSS	Plans are required to assume full risk for IHSS provider payments (i.e., wages and benefits, such as health insurance). The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December. CalOptima Board of Directors would likely have to make a "go / no-go" decision on the 3-way contract for Cal MediConnect in December without the opportunity to review the CDSS contract.
After-hours call capacity	Plans cannot leverage current 24-hour Nurse Advice Lines to meet the after-hours call capacity requirement as the after-hours call service needs to be staffed either by a physician or an appropriate licensed professional under his or her supervision.

Requirement / Area of Concern	Impact
Pending contracts and regulatory guidance	The Agreement incorporates requirements to comply with unissued CMS/DHCS guidance. These references in the Agreement are broad and are not limited to indicating that the guidance will do no more than interpret current requirements under State and Federal laws.
Advisory Committee	Requires the formation of a new Advisory Committee to the Board of Directors, which must consist of not more than eleven (11) people, and no less than fifty percent (50%) of the membership of the advisory committee shall be individuals who are users of personal assistance paid for through public or private funds or recipients of IHSS services.

Other issues related to the Three-Way Agreement for Cal MediConnect include:

- Lack of specific information on IHSS;
  - Data sharing issues with the California Department of Social Services (CDSS) for IHSS; and
  - Contract terms for agreement with CDSS. The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December.

- Reporting requirements not yet specified (e.g., network adequacy, performance measures).

Revisions to CalOptima's FY 2013-14 Implementation, Operating, and Capital Budgets
Staff is submitting revisions to the FY 2013-14 Implementation, Operating, and Capital Budget to the BOD for approval with assumptions based on currently available information.

Proposed Budget 1/1/14 – 6/30/14			
	Implementation	**Operational**	**Total**
Average Monthly Enrollment	N/A	7,118	7,118
Revenue	$0	$43,130,331	$43,130,331
Medical Costs	$2,845,316	$38,414,385	$41,259,701
Administrative Costs	$2,879,267	$4,069,166	$6,948,433
Operating Income/(Loss)	($5,724,583)	$646,780	($5,077,803)
Medical Loss Ratio (MLR)	N/A	89.1%	95.7%
Administrative Loss Ratio (ALR)	N/A	9.4%	16.1%
Capital – Hardware/Software			$1,100,000

Enrollment Assumptions:
- Begins April 1, 2014 with an estimated 3,680 members
- Assumes a pre-enrollment opt-out rate of 20% and disenrollment rate of 5%

- CY 2014 enrollment will consist of FFS Medicare membership, since Medicare Advantage enrollees are allowed to stay with existing plan through Dec 2014

Revenue Assumptions:
- Bases Medicare rates on draft rates provided in October 2013
- Bases Medi-Cal rates on draft rates provided on November 20, 2013
- Estimates total revenue of $2,019.74 per member per month
- Medicare Part A/B and Part D rates utilizes a base rate and applies a risk adjustment factor (similar to OneCare revenue)
- Medi-Cal rate is a blended rate of four population cohorts: LTC, HCBS High, HCBS Low, and Community Well
- Adjusts rates for savings targets that escalate from 1.4% to 5.5% over the next three and a half years

Medical Cost Assumptions:
- Assumes an average provider capitation rate of 37.5% of Medicare Part A/B premium
- Uses current OneCare medical utilization and unit cost rates as a proxy
- Assumes an MLR of 85.3% on prescription drug benefits
- Assumes an MLR of 90.3% on Medi-Cal wrap-around benefits
- Excludes supplemental benefits with the exception of mental health and transportation services
- Includes program guidelines that require higher levels of Case Management and Health Services
- Estimates eighty-two (82) FTE's are scheduled over the remainder of the year

Administrative Cost Assumptions:
- Includes implementation costs of $5.7 million to prepare the organizations processes, policies, and staff for a targeted go-live date of April 1, 2014
- Program guidelines specify staffing requirements, such as Compliance and Customer Service
- Estimates sixty-three (63) FTE's are scheduled over the remainder of the year
- First twelve (12) months of the program will require higher than standard level of cost for initial items such as member and provider mailings as well as staff recruitment and training. These costs are staged in to occur approximately three (3) months prior to the member enrollment.

Capital Assumptions:
- Includes hardware and software required to support the increase in staffing and projected membership population

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
CCMS (Medical Database)	$ 222,300	20%
Facets Upgrades	204,300	19%
Backup Environment	67,240	6%
Core Infrastructure	58,020	5%
Data Warehouse	43,000	4%

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
Misc (Network Costs)	505,140	46%
Total	$ 1,100,000	100%

The Proposed budget includes hardware, software, and professional fees.

Next Steps:
After receipt and review of the Three-Way Agreement and analysis of the interim final rates, Staff recommends the BOD to authorize the Chairman to execute the Three-Way Agreement for CalOptima to participate in Cal MediConnect.

Concurrently, Staff will continue to prepare for the implementation of Cal MediConnect and Managed MLTSS.

Approval of the proposed actions and the Board Chair's execution of the three-way agreement with CMS and DHCS will commit CalOptima to participating in the Cal MediConnect Program.

Fiscal Impact
As outlined above, the proposed revisions to the CalOptima FY 2013-14 Implementation and Operating Budget reflect a deficit of $5.1 million and a Capital Budget of $1.1 million.

Rationale for Recommendation
The DHCS proposal to implement the CCI aligns with CalOptima's long standing commitment to better integrate acute and long term care services. This integration initiative provides CalOptima an opportunity to work with community stakeholders to design a system that fully integrates the administrative and financial responsibilities for Medi-Cal and Medicare covered services and achieve its acute and long term care integration goals.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/27/2013*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

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- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: January 8, 2019

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer R. Shapiro, Acting Director, Medicare Plan Payment Group

SUBJECT: **Release of 2019 MIPS Payment Adjustment Data File**

The Centers for Medicare & Medicaid Services (CMS) has uploaded to the Health Plan Management System (HPMS) the Merit-based Incentive Payment System (MIPS) Payment Adjustment Data File for payment year 2019. Medicare Advantage organizations (MAOs) can use the information in the file to determine the amount of the MIPS payment adjustment that applies to their payments for Medicare Part B covered professional services furnished by out-of-network MIPS eligible clinicians.

For guidance on when and how the MIPS payments apply to MAOs' payments to MIPS eligible clinicians, please see the April 27, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments" and the November 8, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance."

File Access

The 2019 MIPS Payment Adjustment Data File has been added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). After navigating to the "Incentive Payments" section, a user may download the file by selecting "MIPS Payment Adjustment Data File" under Step One, "2019" under Step Two, and "Download" under Step Three.

Due to the sensitivity of some of the information provided in the file, only the MAO's Medicare Compliance Officer will be able to access and download it. The Compliance Officer must be a registered HPMS user in order to obtain the file.

Identifying the Applicable MIPS Adjustment Percentage

The MIPS Payment Adjustment Data File consists of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)

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- MIPS adjustment percentage
- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see the attached Appendix.

An MAO can identify the applicable MIPS adjustment percentage for a MIPS eligible clinician by matching the clinician's billing TIN/NPI combination to a TIN/NPI combination in the MIPS Payment Adjustment Data File. If an exact match for the billing TIN/NPI combination does not appear in the data file, the MAO should determine whether the NPI appears in combination with another TIN and, if so, apply the MIPS adjustment percentage associated with that TIN/NPI combination. If the NPI appears in more than one TIN/NPI combination in the data file, the MAO should apply the MIPS adjustment percentage for the TIN/NPI combination that results in the greatest total payment amount.

Additional Information

If you encounter technical difficulties when downloading the MIPS Payment Adjustment Data File from HPMS, you may contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028.

If the "Incentive Payments" hyperlink does not appear in the HPMS Data Extract Facility, you must send a request for additional access to hpms_access@cms.hhs.gov. Please note that information in the MIPS Payment Adjustment Data File is considered sensitive and may require additional levels of approval.

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

Appendix

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

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increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

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Attachment to the September 5, 2019 Board of Directors Meeting – Agenda Item 9

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Regional Operations Group

September 6, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 19-0020, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 30, 2019. SPA 19-0020 continues the Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers to Medi-Cal patients from July 1, 2019 to June 30, 2020.

The effective date of this SPA is July 1, 2019. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard C. Allen
Director
Western Regional Operations Group

cc: Jacey Cooper, California Department of Health Care Services (DHCS)
Lindy Harrington, DHCS
Connie Florez, DHCS
Michelle Tamai, DHCS
Adam Neighbours, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 19 — 00 20

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: Title 42 CFR 447 Subpart F

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ 2019 $ $4,809,054
b. FFY ~~2019~~ 2020 $ $14,427,163

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 29, Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Supplement 29, Attachment 4.19-B, pages 1-2

10. SUBJECT OF AMENDMENT

One-year reimbursement rate add-on for ground emergency medical transports with dates of service between July 1, 2019 and June 30, 2020.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Mari Cantwell

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: July 30, 2019

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: July 30, 2019

18. DATE APPROVED: September 6, 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Richard C. Allen

22. TITLE: Director, Center for Medicaid & CHIP Services, Regional Operations Group

23. REMARKS

For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.

Box 7: CMS pen and ink change to update years per state response to informal questions dated 8/21/19.

FORM CMS-179 (07/92)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, as described below, effective July 1, 2018 through June 30, 2019 and July 1, 2019 through June 30, 2020. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429 BLS Emergency, A0427 ALS Emergency, A0433 ALS2, A0434 Specialty Care Transport, and A0225 Neonatal Emergency Transport. An "emergency medical transport" does not occur when, following evaluation of a patient, a transport is not provided.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for SFY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 is $339.00. The add-on is paid on a per-claim basis.

For SFY 2019-20, the reimbursement rate add-on is fixed. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, A0433, and A0434 is $339.00, and for CPT Code A0225 is $400.72. The add-on is paid for each eligible CPT Code on a per-claim basis.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

Service Code	Description	Current Payment*	Add On Amount	Resulting Total Payment
A0429	Basic Life Support, Emergency	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00
A0434	Specialty Care Transport	$118.20	$220.80	$339.00
A0225	Neonatal Emergency Transport	$179.92	$220.80	$400.72

*These are the base rates associated with these codes, but are subject to further adjustments pursuant to the State Plan.

The resulting total payment amount as listed in the table above for the applicable CPT Code is considered the Rogers rate, which managed care organizations shall pay noncontract managed care emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code, for each state fiscal year the FFS reimbursement rate add-on is effective.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

Contact

Michelle Laughlin, Executive Director, Network Operations (714) 246-8400
Nancy Huang, Interim Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the OneCare Connect Health Network contracts with AltaMed Health Services Corporation to:

i. Extend the OneCare Connect Health Network contract through and including December 31, 2020;
ii. Add any necessary language provisions required based on the Three-Way Cal MediConnect contract (Three-Way Agreement) between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements, including language reflecting changes related to the Merit-based Incentive Payments System (MIPS) program; and
iii. Clarify access standards for prenatal care.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (CMC) OneCare Connect beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

Cal MediConnect was launched in 2014 as a three-year demonstration program implemented across eight counties. OneCare Connect (OCC) was launched July 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated Health Networks to manage services to the network's assigned membership.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019. At its November 2018 meeting, the Board authorized CalOptima to extend the Health Network contracts for one year through December 31, 2019.
At its October 3, 2019 meeting, the Board authorized execution of the newest version of the three-way agreement, which became effective September 1, 2019. Among the key changes of the new agreement was extension of the Cal MediConnect demonstration period through, December 31, 2022, in one-year

terms. In accordance with this change, staff is seeking authorization to extend the Health Network agreements for an additional year through December 31, 2020.

Discussion

Language Provisions; Agreement with CMS and DHCS

Contract amendments will be required to include provisions to address technical revisions and any other new/revised requirements from the new Three-Way Agreement that are applicable to the OneCare Connect Health Networks. To be in compliance with the most current version of the Three-Way Agreement received from DHCS, effective September 1, 2019, staff seeks authority to amend OneCare Connect Health Network contracts to ensure contracted OCC Health Networks ensure that providers are enrolled with DHCS as Medicaid providers consistent with all Medicaid enrollment requirements. Other changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Merit-based Incentive Payment Systems (MIPS)

In accordance with the Medicare Access and CHIP Reauthorization Act of 2015 Quality Payment Program memorandum and CalOptima Policies and Procedures, Health Networks implemented the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. This provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Payment to health networks is contingent upon annual receipt of their provider payment adjustment confirmation report, which identifies and reports all claims qualifying for MIPS payment adjustments. Health Networks are required to submit their adjustment reports on an annual basis, starting July 2020. For dates of service January 1, 2019 through December 31, 2019, payment year is 2021. Staff seeks authority to amend contracts to include language in support of the MIPS payment adjustments to the OCC Health Networks to remain in compliance with this CMS-mandated program.

Access Standards for Prenatal Care

As it relates to maternity services and access standards for prenatal care, the OneCare Connect Contract will be updated to be consistent with CalOptima's Medi-Cal Health Network contracts. The Medi-Cal Health Network contract language ensures that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for prenatal services and ensure that Physician Groups have a process in place for follow-up on Member missed appointments.

Summary of Recommendations

Staff seeks Board authorization to amend the Health Network agreements as needed to extend and add any necessary language provisions required by the Three-Way Agreement, and to include language supporting the provision for MIPS, ACOG and GEMT.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect Health Network capitation expenses of $131 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The

recommended action to renew the existing Health Network contracts through June 30, 2020 is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extensions, in the CalOptima FY 2020-21 Operating Budget.

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OCC members is maintained, allows flexibility to modify OCC Health Network contracts as needed based on CalOptima's Three-Way Agreement with DHCS and CMS, support CalOptima's payment obligations under the MIPS program, and ensure access standards for prenatal care are aligned with the most current ACOG standards and guidelines.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated December 5, 2013; Consider Participation in the Cal MediConnect Program
3. Board Action dated September 7, 2017; Authorize and Direct Execution of a New Three-Way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program
4. Board Action dated November 1, 2018; Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts
5. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
6. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
7. CMS Release of 2019 MIPS Payment Adjustment Data File

/s/ Michael Schrader — *10/30/2019*

Authorized Signature — **Date**

AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. C. Consider Participation in the Cal MediConnect Program

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400
Patti McFarland, Chief Financial Officer, (714) 246-8400

Recommended Actions
Consider the following required actions to participate in the Cal MediConnect Program:
1. Authorize and Direct the Chairman of the Board of Directors to Execute the Three-Way Agreement between the California DHCS, CMS and CalOptima for Cal MediConnect, subject to the interim final rates that will not harm the financial viability of CalOptima and reasonable and expected requirements related to operations and reporting;
2. Authorize and Direct the Chairman of the Board of Directors to Execute the California Department of Social Services' (CDSS) Contract for In-Home Supportive Services (IHSS);
3. Approve Revisions Related to Cal MediConnect to CalOptima's Fiscal Year (FY) 2013-14 Budget; and
4. Authorize the CEO to develop and/or update policies necessary to meet Cal MediConnect participation requirements and implement the program's benefit set.

Background
In June 2012, Senate Bill 1008 (2012) and SB 1036 (2012) authorized the Coordinated Care Initiative (CCI). The CCI is composed of two (2) key components that will work in tandem to improve care coordination and integration.

1. Cal MediConnect: No sooner than April 1, 2014, the state will begin a three (3) year federal-state demonstration program in eight (8) counties. Individuals with Medicare and Medi-Cal (i.e., dual eligible beneficiaries) will receive coordinated medical, behavioral health, institutional long-term care, and home and community based services through a single Medi-Cal managed care plan. The participating counties are: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside, and San Bernardino.

2. Managed Medi-Cal Long-Term Supports and Services (MLTSS): No sooner than April 1, 2014, all Medi-Cal beneficiaries, including dual eligible beneficiaries, will receive long-term services and supports and Medi-Cal wrap-around benefits through a Medi-Cal managed care plan. MLTSS includes institutional long-term care, Community Based Adult Services, Multipurpose Senior Services Program, and IHSS.

   As a County Organized Health System (COHS), CalOptima already serves dual eligible beneficiaries, and provides Medi-Cal wrap-around services to members. In addition, pursuant to SB 94 (2013), DHCS separated the MLTSS component from the Cal MediConnect program. Medi-Cal managed care plans will provide MLTSS as a Medi-Cal benefit to all enrollees even if Cal Medi-Connect does not move forward.

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DHCS initially proposed to implement Cal MediConnect no sooner than January 1, 2014. However, DHCS revised the timeline several times to accommodate ongoing negotiations with CMS and to resolve other implementation issues. On August 13, 2013, DHCS formally announced that Cal MediConnect will begin no sooner than April 1, 2014. Initial enrollment will occur on a passive enrollment basis for a twelve (12) month period, based on the eligible beneficiary's birthday month.

CalOptima's FY 2013-14 Operating Budget projected an increased enrollment of 27,000 members from the Cal MediConnect program through June 30, 2014. Staff will make a downward adjustment to the membership projection due to the delayed implementation date, and anticipates approximately 3,700 members will be passively enrolled each month. Staff will implement strategies to minimize the opt-out rate of the Cal MediConnect program.

The Demonstration Years for the Cal MediConnect program are as follows:

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

On May 3, 2012, your Board approved a pre-implementation budget for the CCI of $373,994 to proceed with the application process to participate in the program. The funds were used to support travel and training, consultant fees, limited term staffing, and outreach and engagement. The budget was for the period of May 3, 2012, through August 31, 2012.

On January 3, 2013, your Board approved additional funding to continue pre-implementation planning for the CCI of $615,000 for a total of $988,994. The funds were used to support professional fees and staffing. To date, approximately ninety-five percent (95%) of the pre-implementation funds have been spent. Based on Board approval, staff has completed all state and federal applications and additional requests, including but not limited to:

Key Deliverables	Date
DHCS Request for Solutions	February 23, 2012
CMS Capitated Financial Alignment Demonstration application	May 23, 2012
Proposed Model of Care	June 29, 2012
Proposed Medication Management Therapy Program	May 6, 2013
Proposed Part D Formulary	May 31, 2013
Proposed Plan Benefit Package	June 3, 2013
Revised Health Service Delivery Tables for Network Validation	June 26, 2013

Key steps and milestones for the Cal MediConnect program are as follows:

Key Steps and Milestones	Date
Finalize Memorandum of Understanding (MOU) (CMS and DHCS)	Executed March 27, 2013

Key Steps and Milestones	Date
Develop final capitation rates	Ongoing since April 23, 2013
Conduct joint readiness assessments (CMS and DHCS)	Initiated March 2013 and ongoing through December 2013 - Desk Review: April 19, 2013 - On-site visit: July 25-26, 2013 - Remote Systems Testing: October 21, 2013 - Network Validation: October 28, 2013 - Pre-Enrollment Validation: November 20, 2013 - Final Readiness report to be issued mid-December 2013
Execute MOUs with relevant county agencies	Completed in July and August 2013
Sign Three-Way contract	December 13, 2013 (electronic signature) December 16, 2013 (hard copy signature)
Sign CDSS contract for IHSS services	Mid-December 2013 (anticipated)
Finalize Plan Benefit Package in CMS system	Mid-December 2013
Implement Cal MediConnect	No sooner than April 1, 2014

On June 6, 2013, your Board approved CalOptima's FY 2013-14 Operating Budget. Staff clarified that the operating budget did not include infrastructure and implementation funding for the Duals Demonstration (i.e., the Cal MediConnect program), and that Staff would present the budget as a separate Board action.

Discussion

Both DHCS and CMS are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of Cal MediConnect. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted, as noted above, from the prior dates shared with the Board in previous meetings. Staff participated in the on-site readiness review July 25-26, 2013.

The next key step is for CalOptima to sign the Three-Way Agreement with CMS and DHCS. Recently, DHCS notified participating plans that the final date by which CMS will require execution of the Agreement is December 10, 2013. Plans, including CalOptima, received the "final" Three-Way Agreement on November 6, 2013 and were advised that they would not be able to negotiate changes to the Agreement. Although the document contains a number of terms that are currently in other program agreements, this was the first time that plans received the document which contains new Cal MediConnect program requirements, Plans had approximately one week to review the document and submit a list of "significant concerns" to the Agreement. DHCS held a conference call with plans on November 20, 2013 to discuss the comments plans submitted. On the call, the DHCS provided clarification on certain terms, but essentially reiterated that the "final" version was, in fact, final. CMS and DHCS issued interim final rates in late October for plans' thirty (30) day review. Additionally, DHCS has indicated that rates may be subject to additional minor revisions prior to the final execution of the Agreement.

Three-Way Cal MediConnect Agreement

The Agreement between DHCS, CMS, and CalOptima outlines the respective obligations for each party to implement the Cal MediConnect program in Orange County. The Agreement contains provisions for CMS

and DHCS to evaluate CalOptima's performance as a Cal MediConnect participating plan, including adherence to federal Medicare and Medicaid laws.

Below are some areas within the Agreement that will have a significant operational and financial impact:

Requirement / Area of Concern	Impact
Benefits and funding streams	The Agreement reflects continued fragmentation of Medicare and Medi-Cal benefits, services, and funding streams will pose operational challenges. Full integration will likely not occur until year 2 of the demonstration.
Care coordination	The Agreement includes extensive care coordination requirements that conflict with the existing Medicare requirements for a plan's Model of Care are included in the Agreement. Specifically, the ten (10) day timeframe to develop Individualized Care Plans (ICPs) for members after completion of the Health Risk Assessment (HRA) is insufficient.
Rate dispute process	The Agreement excludes rates from the dispute process. Requiring participating plans to waive their legal rights to dispute a rate that may be unreasonable or actuarially unsound is particularly problematic in year 2 and 3 of the demonstration.
Quality withholds	There is a lack of specific information on the quality withhold metrics, and how plans will be measured for purposes of earning back the withheld amount based on performance. The agreement lacks a process for plans to provide meaningful input on the performance metrics that will be tied to the quality withholds for each Demonstration year.
IHSS	Plans are required to assume full risk for IHSS provider payments (i.e., wages and benefits, such as health insurance). The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December. CalOptima Board of Directors would likely have to make a "go / no-go" decision on the 3-way contract for Cal MediConnect in December without the opportunity to review the CDSS contract.
After-hours call capacity	Plans cannot leverage current 24-hour Nurse Advice Lines to meet the after-hours call capacity requirement as the after-hours call service needs to be staffed either by a physician or an appropriate licensed professional under his or her supervision.

Requirement / Area of Concern	Impact
Pending contracts and regulatory guidance	The Agreement incorporates requirements to comply with unissued CMS/DHCS guidance. These references in the Agreement are broad and are not limited to indicating that the guidance will do no more than interpret current requirements under State and Federal laws.
Advisory Committee	Requires the formation of a new Advisory Committee to the Board of Directors, which must consist of not more than eleven (11) people, and no less than fifty percent (50%) of the membership of the advisory committee shall be individuals who are users of personal assistance paid for through public or private funds or recipients of IHSS services.

Other issues related to the Three-Way Agreement for Cal MediConnect include:

- Lack of specific information on IHSS;
  - Data sharing issues with the California Department of Social Services (CDSS) for IHSS; and
  - Contract terms for agreement with CDSS. The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December.

- Reporting requirements not yet specified (e.g., network adequacy, performance measures).

Revisions to CalOptima's FY 2013-14 Implementation, Operating, and Capital Budgets
Staff is submitting revisions to the FY 2013-14 Implementation, Operating, and Capital Budget to the BOD for approval with assumptions based on currently available information.

Proposed Budget 1/1/14 – 6/30/14			
	Implementation	**Operational**	**Total**
Average Monthly Enrollment	N/A	7,118	7,118
Revenue	$0	$43,130,331	$43,130,331
Medical Costs	$2,845,316	$38,414,385	$41,259,701
Administrative Costs	$2,879,267	$4,069,166	$6,948,433
Operating Income/(Loss)	($5,724,583)	$646,780	($5,077,803)
Medical Loss Ratio (MLR)	N/A	89.1%	95.7%
Administrative Loss Ratio (ALR)	N/A	9.4%	16.1%
Capital – Hardware/Software			$1,100,000

Enrollment Assumptions:
- Begins April 1, 2014 with an estimated 3,680 members
- Assumes a pre-enrollment opt-out rate of 20% and disenrollment rate of 5%

- CY 2014 enrollment will consist of FFS Medicare membership, since Medicare Advantage enrollees are allowed to stay with existing plan through Dec 2014

Revenue Assumptions:
- Bases Medicare rates on draft rates provided in October 2013
- Bases Medi-Cal rates on draft rates provided on November 20, 2013
- Estimates total revenue of $2,019.74 per member per month
- Medicare Part A/B and Part D rates utilizes a base rate and applies a risk adjustment factor (similar to OneCare revenue)
- Medi-Cal rate is a blended rate of four population cohorts: LTC, HCBS High, HCBS Low, and Community Well
- Adjusts rates for savings targets that escalate from 1.4% to 5.5% over the next three and a half years

Medical Cost Assumptions:
- Assumes an average provider capitation rate of 37.5% of Medicare Part A/B premium
- Uses current OneCare medical utilization and unit cost rates as a proxy
- Assumes an MLR of 85.3% on prescription drug benefits
- Assumes an MLR of 90.3% on Medi-Cal wrap-around benefits
- Excludes supplemental benefits with the exception of mental health and transportation services
- Includes program guidelines that require higher levels of Case Management and Health Services
- Estimates eighty-two (82) FTE's are scheduled over the remainder of the year

Administrative Cost Assumptions:
- Includes implementation costs of $5.7 million to prepare the organizations processes, policies, and staff for a targeted go-live date of April 1, 2014
- Program guidelines specify staffing requirements, such as Compliance and Customer Service
- Estimates sixty-three (63) FTE's are scheduled over the remainder of the year
- First twelve (12) months of the program will require higher than standard level of cost for initial items such as member and provider mailings as well as staff recruitment and training. These costs are staged in to occur approximately three (3) months prior to the member enrollment.

Capital Assumptions:
- Includes hardware and software required to support the increase in staffing and projected membership population

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
CCMS (Medical Database)	$ 222,300	20%
Facets Upgrades	204,300	19%
Backup Environment	67,240	6%
Core Infrastructure	58,020	5%
Data Warehouse	43,000	4%

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
Misc (Network Costs)	505,140	46%
Total	$ 1,100,000	100%

The Proposed budget includes hardware, software, and professional fees.

Next Steps:
After receipt and review of the Three-Way Agreement and analysis of the interim final rates, Staff recommends the BOD to authorize the Chairman to execute the Three-Way Agreement for CalOptima to participate in Cal MediConnect.

Concurrently, Staff will continue to prepare for the implementation of Cal MediConnect and Managed MLTSS.

Approval of the proposed actions and the Board Chair's execution of the three-way agreement with CMS and DHCS will commit CalOptima to participating in the Cal MediConnect Program.

Fiscal Impact
As outlined above, the proposed revisions to the CalOptima FY 2013-14 Implementation and Operating Budget reflect a deficit of $5.1 million and a Capital Budget of $1.1 million.

Rationale for Recommendation
The DHCS proposal to implement the CCI aligns with CalOptima's long standing commitment to better integrate acute and long term care services. This integration initiative provides CalOptima an opportunity to work with community stakeholders to design a system that fully integrates the administrative and financial responsibilities for Medi-Cal and Medicare covered services and achieve its acute and long term care integration goals.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/27/2013*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

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receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

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Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

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- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

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Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: January 8, 2019

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer R. Shapiro, Acting Director, Medicare Plan Payment Group

SUBJECT: **Release of 2019 MIPS Payment Adjustment Data File**

The Centers for Medicare & Medicaid Services (CMS) has uploaded to the Health Plan Management System (HPMS) the Merit-based Incentive Payment System (MIPS) Payment Adjustment Data File for payment year 2019. Medicare Advantage organizations (MAOs) can use the information in the file to determine the amount of the MIPS payment adjustment that applies to their payments for Medicare Part B covered professional services furnished by out-of-network MIPS eligible clinicians.

For guidance on when and how the MIPS payments apply to MAOs' payments to MIPS eligible clinicians, please see the April 27, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments" and the November 8, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance."

File Access

The 2019 MIPS Payment Adjustment Data File has been added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). After navigating to the "Incentive Payments" section, a user may download the file by selecting "MIPS Payment Adjustment Data File" under Step One, "2019" under Step Two, and "Download" under Step Three.

Due to the sensitivity of some of the information provided in the file, only the MAO's Medicare Compliance Officer will be able to access and download it. The Compliance Officer must be a registered HPMS user in order to obtain the file.

Identifying the Applicable MIPS Adjustment Percentage

The MIPS Payment Adjustment Data File consists of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)

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- MIPS adjustment percentage
- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see the attached Appendix.

An MAO can identify the applicable MIPS adjustment percentage for a MIPS eligible clinician by matching the clinician's billing TIN/NPI combination to a TIN/NPI combination in the MIPS Payment Adjustment Data File. If an exact match for the billing TIN/NPI combination does not appear in the data file, the MAO should determine whether the NPI appears in combination with another TIN and, if so, apply the MIPS adjustment percentage associated with that TIN/NPI combination. If the NPI appears in more than one TIN/NPI combination in the data file, the MAO should apply the MIPS adjustment percentage for the TIN/NPI combination that results in the greatest total payment amount.

Additional Information

If you encounter technical difficulties when downloading the MIPS Payment Adjustment Data File from HPMS, you may contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028.

If the "Incentive Payments" hyperlink does not appear in the HPMS Data Extract Facility, you must send a request for additional access to hpms_access@cms.hhs.gov. Please note that information in the MIPS Payment Adjustment Data File is considered sensitive and may require additional levels of approval.

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

Appendix

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Policy:	HH.2005Δ
Title:	**Corrective Action Plan**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/ Richard Sanchez 12/07/2020*
Effective Date:	11/01/1998
Revised Date:	12/03/2020

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE
- ☐ Administrative

I. PURPOSE

This policy defines the requirements for CalOptima and its First Tier, Downstream, and Related Entities (FDRs) for development and submission of an Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) for areas of non-compliant performance, as identified by CalOptima's Office of Compliance.

II. POLICY

A. CalOptima's Office of Compliance shall conduct Auditing, operational Monitoring, and investigations of internal CalOptima departments and its FDRs to ensure compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements related to CalOptima programs.

B. CalOptima's Office of Compliance may require that an internal department or FDR develop an ICAP or CAP response based on the identified area(s) of non-compliance.

C. CalOptima's Office of Compliance shall require CalOptima internal departments and FDRs to bring their operations into full compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements, which CalOptima or its regulators have identified as non-compliant, within time frames established by CalOptima's Office of Compliance.

D. An internal department or FDR shall develop, submit, and take corrective action under an approved ICAP or CAP response in the time and manner required by CalOptima's Office of Compliance.

1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP or CAP request may lead to further action.

2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP, or CAP, request may lead to further action. CalOptima may impose Sanctions for the underlying non-compliant performance that gave rise to the ICAP or CAP request, or the failure to develop, submit, and meet the requirements of the ICAP or CAP request, in accordance with CalOptima Policy HH.2002Δ: Sanctions.

III. PROCEDURE

A. Basis for an ICAP or CAP

1. CalOptima's Office of Compliance shall routinely Monitor performance metrics, conduct routine, or focused, Audits, and conduct ongoing Monitoring and investigations of reported non-compliance for internal departments, or FDRs, through a variety of mechanisms.

    a. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of Audits conducted by federal and state regulatory agencies, including, but not limited to the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Managed Health Care (DMHC).

    b. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of an ICAP/CAP request, or other corrective action, that CalOptima receives from a federal or state regulatory agency that is directly related to the operations of an internal department or FDR.

2. In the event that CalOptima's Office of Compliance determines an internal department, or FDR, has failed to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements, the Office of Compliance may issue an ICAP, or CAP request, to address the problem. CalOptima's Office of Compliance shall coordinate its efforts with CalOptima's Human Resources Department in the event that an ICAP or CAP potentially warrants Employee disciplinary action.

B. ICAP and CAP Issuance and Requirements

1. CalOptima's Office of Compliance shall utilize a standardized ICAP and CAP request template.

2. Non-compliance with specific requirements that have the potential to cause significant Member harm, or place CalOptima's accreditation, participation, and/or contractual status with regulatory agencies in jeopardy will require an ICAP response.

    a. If the finding requires an ICAP request, as determined by CalOptima's Office of Compliance, the internal department or FDR is required to cease non-compliant activities within two (2) business days of receiving the ICAP request.

    b. The internal department or FDR shall provide a written response within three (3) business days of receiving an ICAP request, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the ICAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima's Office of Compliance.

3. A CAP request is the result of material non-compliance with specific requirements that does not rise to the level of an ICAP request.

    a. The internal department or FDR is required to respond to the CAP request within fourteen (14) calendar days. CalOptima's Compliance Officer or Designee may authorize extensions to this timeline on a case-by-case basis. Following the acceptance of the CAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima's Office of Compliance.

4. An ICAP or CAP response shall include the following elements:

a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training, and systems that failed;

b. Steps taken to resolve the deficiency;

c. Steps taken to avoid reoccurrence;

d. Method for implementation and completion of ICAP response or CAP response;

e. Individual(s) responsible for implementation of the ICAP response or CAP response;

f. An attestation by the internal department or FDR conveying a plan to remedy its identified deficiencies; and

g. ICAP response or CAP response completion date(s), as applicable.

C. Unacceptable Resolution to an ICAP or CAP

1. If the resolution to the deficiency is unacceptable or the internal department or FDR fails to respond, CalOptima's Office of Compliance shall issue a written notice to the internal department or the FDR, which shall include:

a. A summary of previous outreach and required action(s);

b. An explanation of why that the resolution was not acceptable, or why a response was not received;

c. A revised response timeline of two (2) business days for an ICAP;

i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or Designee.

d. A revised response timeline of five (5) business days for a CAP;

i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or Designee.

e. Explain the possible consequences, specific to the nature of the issue and degree of completeness in accordance with CalOptima Policy HH.2002Δ: Sanctions;

f. Possibility of escalating to the department's Chief, or the FDR's Chief Executive Officer (CEO) or their Designee; and

g. Possibility of referral to the Audit & Oversight Committee and the Compliance Committee.

D. Acceptable Resolution with ICAP or CAP Requirements

1. A response may be accepted once all requirements outlined in Section III.B.4. of this Policy are fulfilled. If an ICAP or CAP response requires Monitoring or a focused Audit, the ICAP or CAP response shall not be closed until the remediation(s) implemented have been validated by the Office of Compliance and demonstrate that the issue will not recur.

a. A response may be accepted and closed simultaneously if Monitoring or a focused Audit is not required.

2. If the resolution to the deficiency is deemed acceptable by CalOptima's Compliance Officer or Designee, CalOptima's Office of Compliance may issue a written notification of acceptance, which shall include:

   a. An acknowledgement of acceptance;

   b. A description of follow up actions which shall include, but is not limited to:

      i. Submission of finalized documentation; and/or

      ii. Focused Audit, as described in Section III.E. of this Policy; and/or

      iii. Monitoring, as deemed appropriate by CalOptima's Office of Compliance, and as described in Section III.F. of this Policy.

3. If the resolution to the deficiency is accepted and deemed sufficient by CalOptima's Compliance Officer or Designee, CalOptima's Office of Compliance shall issue a written notification of closure, which shall include:

   a. An acknowledgement of closure;

   b. The effective date of closure; and

   c. Consequences of repeat deficiencies.

E. Focused Audits

1. CalOptima's Office of Compliance may conduct a focused Audit of an internal department or FDR to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima's Office of Compliance shall notify the internal department or FDR of the scope, Audit period, and Audit deliverables that shall be required to complete the focused Audit.

3. CalOptima's Office of Compliance may continue to Monitor and/or Audit an internal department or FDR for performance of issues and/or functions related to the ICAP or CAP request.

F. Monitoring Period

1. CalOptima's Office of Compliance may conduct Monitoring of the internal department's or FDR's resolution to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima's Office of Compliance shall Monitor the resolution for a predetermined time frame, as established by CalOptima's Office of Compliance.

3. CalOptima's Office of Compliance shall notify the internal department, or FDR, of the scope, Monitoring period, and deliverables that shall be required to complete the Monitoring.

4. CalOptima's Office of Compliance may continue to Monitor and/or Audit an internal department's or FDR's performance of issues and/or functions related to the ICAP or CAP request.

G. Failure to Maintain Adequate Resolution

1. If during the Monitoring period or the focused Audit the internal department or FDR fails to maintain the remedies in place, CalOptima's Office of Compliance may issue the internal department or FDR an ICAP or CAP request, as appropriate.

2. If an ICAP request is issued, the internal department or FDR shall be required to resolve the issue within two (2) business days from the re-issuance of the finding.

   a. Extensions to this timeline may be authorized on a case-by-case basis by the Compliance Officer, or Designee.

3. The ICAP request shall require the information as described in Section III.B.4. of this Policy.

H. ICAP and CAP Tracking and Reporting

1. CalOptima's Office of Compliance shall track all CAP and ICAP requests issued utilizing a standardized tool.

2. CalOptima's Office of Compliance shall report the status of all CAP/ICAP requests to the Audit & Oversight Committee and the Compliance Committee.

3. In the event that CalOptima's Office of Compliance issues an ICAP request with respect to the CalOptima Medi-Cal Program, the Regulatory Affairs & Compliance Department shall report the issue to CalOptima's DHCS Contract Manager for Medi-Cal within three (3) business days of issuance.

4. If CalOptima's internal department, or FDR, has repeat deficiencies, the issue(s) shall be reported to the Audit & Oversight Committee and the Compliance Committee by the Office of Compliance for further action.

IV. ATTACHMENT(S)

A. ICAP/CAP Request Template

V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy HH.2002Δ: Sanctions
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Department of Health Care Services (DHCS) All Plan Letter 17-004: Subcontractual Relationships and Delegation
H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9

J. Title 22, California Code of Regulations (CCR), §51301 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
08/02/2018	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1998	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	10/01/2002	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Effective	08/01/2005	MA.9104	Corrective Action Plan	OneCare
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	08/01/2008	MA.9104	Corrective Action Plan	OneCare
Revised	04/01/2013	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare
Revised	04/01/2014	MA.9104	Corrective Action Plan	OneCare
Revised	12/01/2014	MA.9104	Corrective Action Plan	Cal MediConnect OneCare PACE
Revised	09/01/2015	HH.2005	Corrective Action Plan	Medi-Cal
Revised	09/01/2015	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	08/02/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Audit & Oversight Committee	A subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in the AOC charter.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier Entities and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
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.
Employee	For purposes of this policy, any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDRs)	First Tier Entity: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program. Downstream Entity: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services. Related Entity: Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two-thousand five-hundred dollars ($2,**500)** during a contract period.

Term	Definition
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Immediate Corrective Action Plan (ICAP) Request	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	A beneficiary who is enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a First Tier Entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

AMENDMENT {XXXXXX} TO

CAL MEDICONNECT PHYSICIAN GROUP SERVICES CONTRACT

This Amendment {XXXXX} to the Cal MediConnect Physician Group Services Contract ("Amendment") is effective as of January 1, 2022, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, {_____} ("Physician Group"), with respect to the following facts:

RECITALS

A. Physician Group and CalOptima have entered into a Cal MediConnect Physician Group Services Contract ("Contract") for the provision of specified covered services to CalOptima members in identified CalOptima Programs.

B. CalOptima and Physician Group desire to amend the Contract to extend the term of the Contract and revise the Corrective Action Plan time frame.

NOW, THEREFORE, the parties agree as follows:

1. Section 11.1 "Term of the Contract" shall be deleted in its entirety and replaced with the following:

   "11.1 **Term of Contract.** This Contract will commence on June 1, 2015 (Effective Date") and will remain in effect until December 31, 2022."

2. Section 11.3.1 shall be deleted in its entirety and replace with the following:

   "11.3.1 CalOptima may require a CAP if it receives a substantiated complaint or grievance related to the Physician Group or any Downstream Entities' non-compliance with statutory, regulatory, contractual, policy or other requirements in accordance with the CAP timing, content and other requirements of CalOptima's corrective action plan and other applicable policies.

3. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS THEREOF, CalOptima and {Insert HN Name Here} have executed this Amendment {Insert Amendment # Here}:

FOR PHYSICIAN GROUP:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	_____
PRINT NAME	PRINT NAME
_____	_____
TITLE	TITLE
_____	_____
DATE	DATE

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

22. Consider Authorizing Amendment to the OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly Behavioral Health Care Services Contract with the Orange County Health Care Agency

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly (PACE) Behavioral Health Care Services Contract with the Orange County Health Care Agency to exercise the second and final, one-year renewal option to extend the contract through December 31, 2022.

Background and Discussion

With the approval of the CalOptima Board of Directors (Board) in April 2013, CalOptima entered into a contract with the County of Orange (County) for the provision and coordination of behavioral health services including substance abuse services, mental health screening, psychotherapy, and psychiatrist services through contracted, Medicare-approved County clinics. In 2017, the Board approved renewal of the contract via an amendment, through December 31, 2020, with two additional mutual one-year renewal options subject to further Board of Directors and HCA approval. In October 2020, the Board, along with HCA, approved the first renewal option, extending the contract through December 31, 2021.

In the current calendar year, the County has provided behavioral health services to over 1,100 CalOptima members with serious and persistent mental illness requiring a specialty mental health service level of care. Preserving access to behavioral health services is critical to ensuring members with serious and persistent mental illness receive the care they need in a timely fashion. As such, staff requests Board approval to execute a contract amendment with the County to exercise the second one-year renewal option, extending the contract through December 31, 2022.

Fiscal Impact

The recommended action to extend the Behavioral Health Services Contract with the Orange County Health Care Agency through December 31, 2022, under the same terms and conditions, has no additional fiscal impact to the CalOptima Fiscal Year (FY) 2021-22 Operating Budget. Management will include funding for the period of July 1, 2022, through December 31, 2022, in the CalOptima FY 2022-23 Operating Budget.

Rationale for Recommendation

Amending the contract with the Orange County Health Care Agency will ensure continued access to behavioral health services for CalOptima's OneCare, OneCare Connect and PACE members.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. Previous Board Action October 1, 2020: Consider Authorizing Amendments to the OneCare and OneCare Connect Behavioral Health Care Services Contract with the Orange County Health Care Agency
3. Previous Board Action December 7, 2017: Consider Authorizing Extension of the Coordination and Provision of Behavioral Health Care Services Contract Between CalOptima and the County of Orange, through its Division the Orange County Health Care Agency, that Expires December 31, 2017
4. Proposed Amendment VII to the OneCare and OneCare Connect Behavioral Health Care Services Contract with the Orange County Health Care Agency

Board Actions

Board Meeting Dates	Action
October 1, 2020	1. Extend through December 31, 2021 2. Add language incorporating provision of opioid use disorder treatment into the contract
December 7. 2017	1. Extend through December 1, 2020, with two (2) mutual one-year extension options
April 4, 2013	1. Enter into contracts with the County of Orange and its subcontracted providers for the provision of certain Medicare-reimbursable mental health services to OneCare members with a serious and persistent mental illness (SPMI) who require the additional outpatient behavioral health services and supports at a higher level of care funded by Short-Doyle Medi-Cal and Mental Health Services Act (MHSA). 2. Amend CalOptima's current contract with Windstone to clarify its obligations with regard to the provision of these services.

/s/ Richard Sanchez — *10/28/2021*
Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Orange County Health Care Agency	405 W. 5th Street	Santa Ana	CA	92701

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
27. Consider Authorizing Amendments to the OneCare and OneCare Connect Behavioral Health Care Services Contract with the Orange County Health Care Agency

Contact
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to Amend the Behavioral Health Care Services Contract with the Orange County Health Care Agency (County of Orange) to:

1. Extend the contract through December 31, 2021; and
2. Add language incorporating the provision of opioid use disorder treatment into the contract

Background
With Board approval granted in April 2013, CalOptima entered into a Behavioral Health Care Services Contract with the County of Orange (County). Under this contract, OneCare and OneCare Connect members with serious and persistent mental illness can receive certain Medicare reimbursable mental health services under the County's Behavioral Health programs. This contract was most recently renewed via amendment in 2017, until December 31, 2020, with two (2) additional one-year (1) renewal terms, subject to CalOptima Board and Health Care Agency approval. The processes that have been put in place with the Orange County Health Care Agency for the coordination of care and provision of Medicare-covered behavioral health services have provided much needed services to CalOptima's OneCare and OneCare Connect members since 2013.

Discussion
As of January 2020, the Centers for Medicare & Medicaid Services (CMS) established the Opioid Treatment Program (OTP) as a benefit under Medicare, requiring all Medicare Advantage Plans, including CalOptima, to participate effective January 1, 2020. OTPs provide medication assisted treatment in combination with counseling and behavioral therapies to offer a "whole-person" approach to treating opioid use disorders. Under the Calendar Year 2020 Physician Fee Schedule final rule, Medicare will cover opioid use disorders treatment services for members having Medicare Part B (OneCare and OneCare Connect), effectively transferring financial responsibility from the Drug Medi-Cal program to Medicare. As a Medicare Advantage Special Needs Plan (D-SNP), and Cal MediConnect Plan (Coordinated Care Initiative), CalOptima will make this service available to OneCare and OneCare Connect members through contracted, Medicare approved treatment centers.

To ensure continuity of Behavioral Health Services, including the provision of opioid use disorders treatment for OneCare and OneCare Connect members, staff requests approval to enter into amendments with the County to exercise the first one-year (1) extension and add language reflecting the provision of opioid use disorders treatment as a covered outpatient service.

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Fiscal Impact

The recommended action to extend the Behavioral Health Care Services Contract with the County of Orange through December 31, 2021, and to add language incorporating the provision of opioid use disorder treatment for the OneCare and OneCare Connect programs is expected to be budget neutral.

Rationale for Recommendation

Amending the Contract with the Orange County Health Care Agency will ensure continued access to Behavioral Health Services, including opioid use disorders treatment, for CalOptima's OneCare and OneCare Connect members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated December 7, 2017

/s/ Richard Sanchez — *09/23/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Orange County Health Care Agency	405 W. 5th St.	Santa Ana	CA	92701

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

17. Consider Authorizing Extension of the Coordination and Provision of Behavioral Health Care Services Contract Between CalOptima and the County of Orange, Through its Division the Orange County Health Care Agency, that Expires December 31, 2017

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Donald Sharps, Medical Director, Behavioral Health Integration, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer (CEO) or his designee, with the assistance of legal counsel, to enter into an amendment to the OneCare and OneCare Connect Coordination and Provision of Behavioral Healthcare Services Contract between CalOptima and the County of Orange through its division the Orange County Health Care Agency (HCA) to extend the agreement through ~~June 30, 2018, with four (4) additional one-year extension options,~~ December 31, 2020, with two (2) one-year extension options, exercisable upon approval by the CalOptima Board and the County of Orange.

Rev 12/7/2017

Background/Discussion

At the April, 4, 2013 Board of Directors meeting, the Board authorized the CEO to enter into the Coordination and Provision of Behavioral Healthcare Services Contract with the County of Orange for the provision of certain Medicare reimbursable mental health services to OneCare members with a serious and persistent mental illness (SPMI) who require the additional outpatient behavioral health services and supports at a higher level of care funded by Short-Doyle Medi-Cal and the Mental Health Services Act (MHSA).

Based on the January 3, 2013 Board action, this contract was amended in 2013 to add the Duals Demonstration (OneCare Connect) program. Following DHCS instruction dated February 21, 2014 which delayed the program start to July 1, 2014, and a subsequent DHCS delay to July 1, 2015, , the contract was amended again in 2015 to specify that the OneCare Connect program would begin no sooner than July 1, 2015, and that the contract would remain in effect through December 31, 2017.

CalOptima staff is requesting Board approval to extend this contract through June 30, 2018. The contract with the County of Orange is on a fixed term basis requiring a contract amendment for any approved extension. CalOptima staff requests that, the contract term language be modified in a fashion similar to other CalOptima provider contracts. In addition to the extension through June 30, 2018, staff is requesting authority to amend the contract so that it may renew on a fiscal year basis, for four (4) additional one-year terms, each exercisable upon CalOptima Board and County approval.

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Fiscal Impact
The recommended action to authorize the extension of the Behavioral Health Care Services Contract between CalOptima and the Orange County HCA for the OneCare and OneCare Connect programs is expected to be budget neutral.

Rationale for Recommendation
The extension of this contract will support the processes that have been put in place with the Orange County Health Care Agency for the coordination of care and provision of Medicare-covered behavioral health services to ensure that members received needed services. As such, staff requests that the Board authorize amendment of the current Coordination and Provision of Behavioral Healthcare Services Contract as recommended.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated January 3, 2013, Authorize the Chief Executive Officer to Develop a Provider Delivery System in Preparation for Implementation of the Duals Demonstration, Including Related Financial Modeling and Contract Template Development
2. Board Action dated April 4, 2013, Authorize the Chief Executive Officer (CEO) to Contract with the County of Orange and its Subcontracted Providers for the Provision of Certain Behavioral Health Services to OneCare Members with a Serious and Persistent Mental Illness (SPMI) and to Amend CalOptima's Contract with Windstone Behavioral Health (Windstone) to Clarify Its Obligations with Regard to the Provision of Certain Behavioral Health Services to OneCare members with SPMI

/s/ Michael Schrader — *11/30/2017*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken January 3, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. E. Authorize the Chief Executive Officer to Develop a Provider Delivery System in Preparation for Implementation of the Duals Demonstration, Including Related Financial Modeling and Contract Template Development

Contact

Javier Sanchez, Executive Director, CalOptima Care Network, (714) 246-8400

Recommended Actions

1. Ratify amendments to existing and currently approved OneCare Participating Medical Group (PMG), Hospital and Ancillary medical provider contracts which include the stated intent to participate in the Duals Demonstration, with the final contract terms subject to future Board approval; and
2. Authorize the Chief Executive Officer to expand the provider delivery system for the purpose of preparing for the implementation of the Duals Demonstration, including conducting related financial modeling, development of contract templates with the assistance of legal counsel, and including the following:
    a. Issuing a Request for Proposal (RFP) to seek proposals from health care entities including those not currently contracted with OneCare such as organized medical groups and health plans which desire to contract with CalOptima to provide services as part of the Duals Demonstration through alternative financial/ risk delegation models; and authorize staff to use existing OneCare criteria to evaluate providers' delegation readiness, as applicable, and subject to refinement based on final Duals Demonstration requirements;
    b. If necessary for continuity of care, utilizing the CalOptima Care Network (CCN) to serve Duals Demonstration members through CCN's directly contracted network of providers; and
    c. Authorizing the CEO, with the assistance of legal counsel, to enter into Letters of Intent (LOI) with selected RFP responders memorializing the intent to participate in the Duals Demonstration. The final contract terms are subject to future Board approval, as well as state and federal approval, as required.

1/3/13: Recommended action #2 continued for 30 days.

Background

CalOptima currently serves approximately 74,000 members who are dually eligible for both Medicare and Medi-Cal ("dual eligibles"). The CalOptima Board previously approved CalOptima's intention to partner with both the federal and state governments to establish a Duals Demonstration for dually eligible individuals in Orange County. As a Duals Demonstration Plan, CalOptima would be able to coordinate the full array of health care benefits for dually eligible individuals, including both Medicare covered benefits, Medi-Cal covered wrap-around services and Medi-Cal Long Term Services and Supports.

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At its May 2012 meeting, the CalOptima Board authorized the CEO to complete and submit an application to CMS and the DHCS to obtain designation as a Duals Demonstration. At that time, the Board also authorized the CEO to spend pre-implementation startup costs of not-to-exceed $373,994 to secure the necessary resources to meet regulatory requirements for the development of the Demonstration. The initial application requirements were submitted and staff continues to respond to additional inquiries regarding the application. CMS and DHCS plan to conduct plan readiness assessments in October or November 2012.

While Duals Demonstration details are in the process of being finalized by CMS and DHCS, management's understanding is that the proposed method of enrollment of members into the Demonstration is through passive enrollment of members who do not actively opt out. This is similar to the approach used at the start of CalOptima's OneCare program in 2005. At that time, there were approximately 55,000 dual eligible members in Orange County. Most of these individuals were passively enrolled into OneCare; however, within several months of OneCare's start-up, approximately 75% of these individuals actively disenrolled from the program. While OneCare has experienced steady and consistent growth since inception, it continues to experience the disenrollment of members who are unable to access providers not contracted with OneCare.

Discussion

The potential enrollment for the first year of the Duals Demonstration is projected to be approximately 50,000 Orange County dual eligible members currently in fee-for-service (FFS). Enrollment is scheduled to begin in June 2013 and will continue for 12 months. To ensure member continuity of care to the fullest extent feasible under the Demonstration, CalOptima staff desires to engage providers who already serve dual eligible members in FFS Medicare but have not participated in OneCare to their fullest capacity, do not contract with one of CalOptima's contracted PMGs under the OneCare program, or do not currently contract with CalOptima at all. Inclusion of providers that currently serve members in FFS Medicare would ensure adequate network capacity, geographic coverage and cultural competence and would support member engagement in the Demonstration.

Stakeholder Vetting Process

The Board's Provider Advisory Committee (PAC) recently undertook an input and vetting process that included formation of an ad hoc workgroup to consider options for the duals demonstration provider delivery system and offer guidance regarding provider engagement. The workgroup's recommendations regarding delivery system expansion and options for provider participation were approved by the PAC at its June 14, 2012 meeting. The recommendations have been incorporated into this proposal, summarized in the subsequent section.

The ad hoc workgroup, which includes representatives from hospitals, trade associations CalOptima's contracted health networks, HMOs, some ancillary and DME providers, as well as

individual medical providers, and other stakeholders continues to meet weekly to develop recommendations to maximize provider participation in the duals demonstration.

Building on CalOptima's OneCare Provider Network

CalOptima was selected to participate in the Duals Demonstration in part because of its experience providing quality of care to dual eligible members in the OneCare program. Staff's proposal is to leverage the OneCare provider network of currently contracted medical groups, hospital and ancillary providers, and additional medical groups approved to participate in the near future, as the basis for the Duals Delivery system. In preparation for the joint CMS and DHCS plan readiness review, staff proposes to leverage existing OneCare contracts. While the final readiness requirements have not been released, staff anticipates that both CMS and DHCS will require plans to provide signed contracts to demonstrate a provider network. For this reason, it is necessary to ratify amendments that were executed with currently contracted PMGs, which state the provider's intent to enter into a contract with CalOptima for the Duals Demonstration subject to the negotiation of final contract terms and Board approval.

Provider Delivery System Expansion

Staff recommends expanding on the existing OneCare delivery system to execute a successful Duals Demonstration that includes as many provider choice options for the 50,000 dual eligibles currently in FFS Medicare as possible. To achieve one of the important the goals of the Demonstration to maintain continuity of care and member/physician relationships for Duals who choose or are passively enrolled in the Dual Demonstration, it is imperative that CalOptima allow flexible options to participate in the Duals Demonstration for providers who currently provide services to Duals outside of CalOptima in Medicare FFS. CalOptima's experience in OneCare from start up indicate that if members are not able to maintain access to providers of their choice, members will exercise their right to disenroll from the Demonstration. The RFP process would allow providers to express their preferred means of participating in the Duals Demonstration:

- Full Delegation/Full Risk (available only in Medi-Cal currently)
- Partial Delegation/Partial Risk – includes Shared Risk (SRG) or Physician Hospital Consortia (PHC) (available in Medi-Cal and OneCare)
- Direct Contract/No Delegation (available only in Medi-Cal currently for limited diagnoses)
- Minimal Delegation (not available currently)

Currently participating delegated medical groups would also have an opportunity to propose new ways to participate in the CalOptima delivery system. For example, current Shared Risk Groups may propose future participation as Full Risk medical groups. Review criteria for such proposals would include evaluation of whether the requesting provider(s) meet the appropriate regulatory risk bearing organization and CalOptima criteria.

This process would also include the development of a contract template for each contracting option to be provided to interested providers. By offering additional contracting options, CalOptima staff anticipates engaging providers who have not traditionally participated with CalOptima (e.g., Medicare FFS providers), as well as expanding opportunities for currently contracted providers. As an example, two HMOs and three health networks currently contracted in CalOptima's Medi-Cal program are not OneCare providers.

CalOptima would enter into LOIs with providers interested in participating in the Duals Demonstration. Once rates are provided, CalOptima staff intends to develop a provider payment methodology that is based on Medicare rates, subject to final negotiations with DHCS and CMS. The final financial aspects of the Duals Demonstration will be provided to the Board for final approval in conjunction with proposed provider contract terms associated with all contracting options and a proposed agreement with DHCS and CMS.

RFP and Evaluation Process

CalOptima would request proposals (RFP) from medical groups and health plans interested in participating as Full Delegation/Full Risk and Minimal Delegation providers. CalOptima intends to evaluate providers and groups based on their ability to meet the minimum quality, administrative and financial participation criteria. Staff is in the process of developing the formal scoring criteria that will be used to evaluate the RFP responses with the assistance of a M.D. Medical Management consultant specializing in network structure. Such criteria would be approved by the Board and would include, but would not be limited to the following:

1. Medi-Cal Managed care experience
2. A requirement to participate in CalOptima's Medi-Cal and Medicare programs
3. A requirement to serve all CalOptima member categories and ages eligible for health network enrollment
4. Applicants must demonstrate the ability to add new providers not currently participating in the CalOptima system
5. Capacity to service seniors and persons with disabilities
6. Accreditation Status (Hospitals must be Joint Commission accredited)
7. Administrative capacity to perform:
    a. Utilization management
    b. Medical management
    c. Credentialing
    d. Quality management
    e. Claims processing and adjudication
    f. Member services and customer service functions
    g. Electronic data interchange
8. SB 260 compliance
9. Financial solvency

10. Financial reserve requirements
11. Cultural and linguistic services
12. Coordination with carve-out agencies
13. Demonstrated capacity to provide, or written subcontracts for the provision of, all covered services, as defined in the Division of Financial Responsibility (DOFR) provided by CalOptima
14. A history of quality patient care and member satisfaction as demonstrated through HEDIS or other approved measures

Recognizing the different strengths and weaknesses among the various groups and the need to maintain as many qualified participating providers as possible, CalOptima staff plans to work with health networks and providers independently in an effort to determine the optimal relationship for all parties involved.

Letters of Intent

To secure a robust delivery system and provider network that offers the best opportunity for a successful Duals Demonstration, it is necessary for CalOptima to secure LOIs with providers ahead of the start date of the Demonstration. Due to the lack of rates and final contractual terms associated with the Demonstration, the only option available to CalOptima is to enter into Letters of Intent (LOI) with down-stream providers selected according to the proposed process described above. With assistance of Legal Counsel, CalOptima staff would draft and execute LOI with providers subject to the final contract terms are to be negotiated and subject to future Board approval.

Fiscal Impact

Significant financial analysis will be performed once the rates for the Duals Demonstration are determined. The Board will have the opportunity to assess CalOptima's participation in the Duals Demonstration and the associated delivery system once rates are received. The rates paid to CalOptima are expected to be based on the current medical costs for Dual Demonstration eligibles, with reductions to generate savings to the State and CMS from the program. The rates paid to providers will be based on the rates paid to CalOptima. CalOptima's best opportunity to mitigate financial risks is to achieve the broadest network of physicians and largest number of members possible. The more CalOptima's Duals Demonstration membership is reflective of the Orange County duals population as a whole, then the more likely the payment rates provided under the program will be adequate. CalOptima will be fully financially responsible for duals that may be served in CCN and will implement a coordinated model of care consistent with prevailing managed care principles in Orange County. CalOptima expects to reduce medical expenses and contribute additional margin as it manages these previously unmanaged members to a medical expense per member more similar to medical expense experience in a managed population.

Rationale for Recommendation

Successful implementation of the Duals Demonstration is predicated in large part on the establishment of a network that includes providers who may not have fully participated with CalOptima or have not contracted with CalOptima previously and are currently providing services for CalOptima dual eligible members in FFS Medicare. To engage these providers, CalOptima recommends the Board consider expanding the Duals Demonstration delivery system to offer a flexible participation model that aligns providers' organizational capacity with their level of desired risk.

Concurrence

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

Attachments

None

/s/ Michael H. Ewing — **Authorized Signature**

12/21/12 — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. H. Authorize the Chief Executive Officer (CEO) to Contract with the County of Orange and its Subcontracted Providers for the Provision of Certain Behavioral Health Services to OneCare Members with a Serious and Persistent Mental Illness (SPMI) and to Amend CalOptima's Contract with Windstone Behavioral Health (Windstone) to Clarify Its Obligations with Regard to the Provision of Certain Behavioral Health Services to OneCare Members with a SPMI

Contact

Clayton Chau, M.D., Medical Director, Behavioral Health, (714) 246-8400

Recommended Actions

Authorize the CEO to:

1. Enter into contracts with the County of Orange and its subcontracted providers for the provision of certain Medicare-reimbursable mental health services to OneCare members with a serious and persistent mental illness (SPMI) who require the additional outpatient behavioral health services and supports at a higher level of care funded by Short-Doyle Medi-Cal and the Mental Health Services Act (MHSA).
2. Amend CalOptima's current contract with Windstone to clarify its obligations with regard to the provision of these services.

Background

CalOptima's OneCare HMO SNP program is responsible for mental health services covered by Medicare. CalOptima has delegated responsibility for the coordination and provision of outpatient mental health services to Windstone since the inception of the OneCare program. CalOptima pays Windstone a per-member-per-month (PMPM) capitation payment for covering and coordinating outpatient and inpatient professional services for OneCare members, including discharge planning and transition from the inpatient setting.

Discussion

In 2012, CalOptima identified that it is necessary for OneCare members with a SPMI, who require the additional outpatient behavioral health services and supports at a higher level of care funded by Short-Doyle Medi-Cal and the MHSA through the County of Orange, to receive their care through those programs. Examples of additional services provided through the county programs include socialization activities, recovery support groups, supported housing program, peer led activities, and medication review and education. At any given time, there are approximately 200 OneCare members who require these services.

As proposed, CalOptima will pay the County of Orange and its contracted programs for the Medicare-covered services (directly to the programs) on a fee-for-service (FFS) basis at 80% of the Medicare fee schedule. The programs have agreed to accept this rate. CalOptima will

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continue to pay a capitation payment to Windstone Behavioral Health for OneCare members while the members are receiving the higher level of outpatient care through the County of Orange and its contracted programs. Windstone will have responsibility for inpatient professional services for these members, including discharge planning and transition from the inpatient setting. In addition, Windstone will coordinate with the County of Orange and its contracted programs for transition to the community level of outpatient care when the member has reached the appropriate level of recovery. Windstone's capitation payments have been adjusted to account for the services paid to the County of Orange and its subcontracted providers on a FFS basis.

CalOptima is currently in discussions with the County of Orange to enter into a formal contract to establish the terms of this agreement to provide services to SPMI members. As proposed, in the meantime, CalOptima will continue to pay for these services on a non-contracted out-of-network FFS basis. CalOptima is also in the process of amending Windstone's current contract to stipulate its responsibilities for coordinating the care of OneCare members who receive outpatient mental health services through the County of Orange and its subcontracted providers.

Fiscal Impact
Payments for these programs during 2012 were less than $100,000. While increased volume is expected based on improved access, minimal financial impact is expected since the FFS payments to the County of Orange and its subcontracted providers is offset by the capitation rate change to Windstone.

Rationale for Recommendation
The proposed approach provides OneCare members with access to the most appropriate level of care in a manner that is seamless to them and based on their clinical need. Access to the Medi-Cal and MHSA-funded components provides OneCare members with the best opportunity for recovery, leading to the combined outcome of a healthier member and reduced system costs.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *3/29/2013*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

17. Consider Authorizing Extension of the Coordination and Provision of Behavioral Health Care Services Contract Between CalOptima and the County of Orange, Through its Division the Orange County Health Care Agency, that Expires December 31, 2017

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Donald Sharps, Medical Director, Behavioral Health Integration, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer (CEO) or his designee, with the assistance of legal counsel, to enter into an amendment to the OneCare and OneCare Connect Coordination and Provision of Behavioral Healthcare Services Contract between CalOptima and the County of Orange through its division the Orange County Health Care Agency (HCA) to extend the agreement through ~~June 30, 2018, with four (4) additional one-year extension options,~~ December 31, 2020, with two (2) one-year extension options, exercisable upon approval by the CalOptima Board and the County of Orange.

Rev 12/7/2017

Background/Discussion

At the April, 4, 2013 Board of Directors meeting, the Board authorized the CEO to enter into the Coordination and Provision of Behavioral Healthcare Services Contract with the County of Orange for the provision of certain Medicare reimbursable mental health services to OneCare members with a serious and persistent mental illness (SPMI) who require the additional outpatient behavioral health services and supports at a higher level of care funded by Short-Doyle Medi-Cal and the Mental Health Services Act (MHSA).

Based on the January 3, 2013 Board action, this contract was amended in 2013 to add the Duals Demonstration (OneCare Connect) program. Following DHCS instruction dated February 21, 2014 which delayed the program start to July 1, 2014, and a subsequent DHCS delay to July 1, 2015, , the contract was amended again in 2015 to specify that the OneCare Connect program would begin no sooner than July 1, 2015, and that the contract would remain in effect through December 31, 2017.

CalOptima staff is requesting Board approval to extend this contract through June 30, 2018. The contract with the County of Orange is on a fixed term basis requiring a contract amendment for any approved extension. CalOptima staff requests that, the contract term language be modified in a fashion similar to other CalOptima provider contracts. In addition to the extension through June 30, 2018, staff is requesting authority to amend the contract so that it may renew on a fiscal year basis, for four (4) additional one-year terms, each exercisable upon CalOptima Board and County approval.

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Fiscal Impact
The recommended action to authorize the extension of the Behavioral Health Care Services Contract between CalOptima and the Orange County HCA for the OneCare and OneCare Connect programs is expected to be budget neutral.

Rationale for Recommendation
The extension of this contract will support the processes that have been put in place with the Orange County Health Care Agency for the coordination of care and provision of Medicare-covered behavioral health services to ensure that members received needed services. As such, staff requests that the Board authorize amendment of the current Coordination and Provision of Behavioral Healthcare Services Contract as recommended.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated January 3, 2013, Authorize the Chief Executive Officer to Develop a Provider Delivery System in Preparation for Implementation of the Duals Demonstration, Including Related Financial Modeling and Contract Template Development
2. Board Action dated April 4, 2013, Authorize the Chief Executive Officer (CEO) to Contract with the County of Orange and its Subcontracted Providers for the Provision of Certain Behavioral Health Services to OneCare Members with a Serious and Persistent Mental Illness (SPMI) and to Amend CalOptima's Contract with Windstone Behavioral Health (Windstone) to Clarify Its Obligations with Regard to the Provision of Certain Behavioral Health Services to OneCare members with SPMI

/s/ Michael Schrader — *11/30/2017*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken January 3, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. E. Authorize the Chief Executive Officer to Develop a Provider Delivery System in Preparation for Implementation of the Duals Demonstration, Including Related Financial Modeling and Contract Template Development

Contact

Javier Sanchez, Executive Director, CalOptima Care Network, (714) 246-8400

Recommended Actions

1. Ratify amendments to existing and currently approved OneCare Participating Medical Group (PMG), Hospital and Ancillary medical provider contracts which include the stated intent to participate in the Duals Demonstration, with the final contract terms subject to future Board approval; and
2. Authorize the Chief Executive Officer to expand the provider delivery system for the purpose of preparing for the implementation of the Duals Demonstration, including conducting related financial modeling, development of contract templates with the assistance of legal counsel, and including the following:
    a. Issuing a Request for Proposal (RFP) to seek proposals from health care entities including those not currently contracted with OneCare such as organized medical groups and health plans which desire to contract with CalOptima to provide services as part of the Duals Demonstration through alternative financial/ risk delegation models; and authorize staff to use existing OneCare criteria to evaluate providers' delegation readiness, as applicable, and subject to refinement based on final Duals Demonstration requirements;
    b. If necessary for continuity of care, utilizing the CalOptima Care Network (CCN) to serve Duals Demonstration members through CCN's directly contracted network of providers; and
    c. Authorizing the CEO, with the assistance of legal counsel, to enter into Letters of Intent (LOI) with selected RFP responders memorializing the intent to participate in the Duals Demonstration. The final contract terms are subject to future Board approval, as well as state and federal approval, as required.

1/3/13: Recommended action #2 continued for 30 days.

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While Duals Demonstration details are in the process of being finalized by CMS and DHCS, management's understanding is that the proposed method of enrollment of members into the Demonstration is through passive enrollment of members who do not actively opt out. This is similar to the approach used at the start of CalOptima's OneCare program in 2005. At that time, there were approximately 55,000 dual eligible members in Orange County. Most of these individuals were passively enrolled into OneCare; however, within several months of OneCare's start-up, approximately 75% of these individuals actively disenrolled from the program. While OneCare has experienced steady and consistent growth since inception, it continues to experience the disenrollment of members who are unable to access providers not contracted with OneCare.

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individual medical providers, and other stakeholders continues to meet weekly to develop recommendations to maximize provider participation in the duals demonstration.

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This process would also include the development of a contract template for each contracting option to be provided to interested providers. By offering additional contracting options, CalOptima staff anticipates engaging providers who have not traditionally participated with CalOptima (e.g., Medicare FFS providers), as well as expanding opportunities for currently contracted providers. As an example, two HMOs and three health networks currently contracted in CalOptima's Medi-Cal program are not OneCare providers.

CalOptima would enter into LOIs with providers interested in participating in the Duals Demonstration. Once rates are provided, CalOptima staff intends to develop a provider payment methodology that is based on Medicare rates, subject to final negotiations with DHCS and CMS. The final financial aspects of the Duals Demonstration will be provided to the Board for final approval in conjunction with proposed provider contract terms associated with all contracting options and a proposed agreement with DHCS and CMS.

RFP and Evaluation Process

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2. A requirement to participate in CalOptima's Medi-Cal and Medicare programs
3. A requirement to serve all CalOptima member categories and ages eligible for health network enrollment
4. Applicants must demonstrate the ability to add new providers not currently participating in the CalOptima system
5. Capacity to service seniors and persons with disabilities
6. Accreditation Status (Hospitals must be Joint Commission accredited)
7. Administrative capacity to perform:
    a. Utilization management
    b. Medical management
    c. Credentialing
    d. Quality management
    e. Claims processing and adjudication
    f. Member services and customer service functions
    g. Electronic data interchange
8. SB 260 compliance
9. Financial solvency

10. Financial reserve requirements
11. Cultural and linguistic services
12. Coordination with carve-out agencies
13. Demonstrated capacity to provide, or written subcontracts for the provision of, all covered services, as defined in the Division of Financial Responsibility (DOFR) provided by CalOptima
14. A history of quality patient care and member satisfaction as demonstrated through HEDIS or other approved measures

Recognizing the different strengths and weaknesses among the various groups and the need to maintain as many qualified participating providers as possible, CalOptima staff plans to work with health networks and providers independently in an effort to determine the optimal relationship for all parties involved.

Letters of Intent

To secure a robust delivery system and provider network that offers the best opportunity for a successful Duals Demonstration, it is necessary for CalOptima to secure LOIs with providers ahead of the start date of the Demonstration. Due to the lack of rates and final contractual terms associated with the Demonstration, the only option available to CalOptima is to enter into Letters of Intent (LOI) with down-stream providers selected according to the proposed process described above. With assistance of Legal Counsel, CalOptima staff would draft and execute LOI with providers subject to the final contract terms are to be negotiated and subject to future Board approval.

Fiscal Impact

Significant financial analysis will be performed once the rates for the Duals Demonstration are determined. The Board will have the opportunity to assess CalOptima's participation in the Duals Demonstration and the associated delivery system once rates are received. The rates paid to CalOptima are expected to be based on the current medical costs for Dual Demonstration eligibles, with reductions to generate savings to the State and CMS from the program. The rates paid to providers will be based on the rates paid to CalOptima. CalOptima's best opportunity to mitigate financial risks is to achieve the broadest network of physicians and largest number of members possible. The more CalOptima's Duals Demonstration membership is reflective of the Orange County duals population as a whole, then the more likely the payment rates provided under the program will be adequate. CalOptima will be fully financially responsible for duals that may be served in CCN and will implement a coordinated model of care consistent with prevailing managed care principles in Orange County. CalOptima expects to reduce medical expenses and contribute additional margin as it manages these previously unmanaged members to a medical expense per member more similar to medical expense experience in a managed population.

Rationale for Recommendation

Successful implementation of the Duals Demonstration is predicated in large part on the establishment of a network that includes providers who may not have fully participated with CalOptima or have not contracted with CalOptima previously and are currently providing services for CalOptima dual eligible members in FFS Medicare. To engage these providers, CalOptima recommends the Board consider expanding the Duals Demonstration delivery system to offer a flexible participation model that aligns providers' organizational capacity with their level of desired risk.

Concurrence

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

Attachments

None

/s/ Michael H. Ewing — **Authorized Signature**

12/21/12 — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. H. Authorize the Chief Executive Officer (CEO) to Contract with the County of Orange and its Subcontracted Providers for the Provision of Certain Behavioral Health Services to OneCare Members with a Serious and Persistent Mental Illness (SPMI) and to Amend CalOptima's Contract with Windstone Behavioral Health (Windstone) to Clarify Its Obligations with Regard to the Provision of Certain Behavioral Health Services to OneCare Members with a SPMI

Contact

Clayton Chau, M.D., Medical Director, Behavioral Health, (714) 246-8400

Recommended Actions

Authorize the CEO to:

1. Enter into contracts with the County of Orange and its subcontracted providers for the provision of certain Medicare-reimbursable mental health services to OneCare members with a serious and persistent mental illness (SPMI) who require the additional outpatient behavioral health services and supports at a higher level of care funded by Short-Doyle Medi-Cal and the Mental Health Services Act (MHSA).
2. Amend CalOptima's current contract with Windstone to clarify its obligations with regard to the provision of these services.

Background

CalOptima's OneCare HMO SNP program is responsible for mental health services covered by Medicare. CalOptima has delegated responsibility for the coordination and provision of outpatient mental health services to Windstone since the inception of the OneCare program. CalOptima pays Windstone a per-member-per-month (PMPM) capitation payment for covering and coordinating outpatient and inpatient professional services for OneCare members, including discharge planning and transition from the inpatient setting.

Discussion

In 2012, CalOptima identified that it is necessary for OneCare members with a SPMI, who require the additional outpatient behavioral health services and supports at a higher level of care funded by Short-Doyle Medi-Cal and the MHSA through the County of Orange, to receive their care through those programs. Examples of additional services provided through the county programs include socialization activities, recovery support groups, supported housing program, peer led activities, and medication review and education. At any given time, there are approximately 200 OneCare members who require these services.

As proposed, CalOptima will pay the County of Orange and its contracted programs for the Medicare-covered services (directly to the programs) on a fee-for-service (FFS) basis at 80% of the Medicare fee schedule. The programs have agreed to accept this rate. CalOptima will

continue to pay a capitation payment to Windstone Behavioral Health for OneCare members while the members are receiving the higher level of outpatient care through the County of Orange and its contracted programs. Windstone will have responsibility for inpatient professional services for these members, including discharge planning and transition from the inpatient setting. In addition, Windstone will coordinate with the County of Orange and its contracted programs for transition to the community level of outpatient care when the member has reached the appropriate level of recovery. Windstone's capitation payments have been adjusted to account for the services paid to the County of Orange and its subcontracted providers on a FFS basis.

CalOptima is currently in discussions with the County of Orange to enter into a formal contract to establish the terms of this agreement to provide services to SPMI members. As proposed, in the meantime, CalOptima will continue to pay for these services on a non-contracted out-of-network FFS basis. CalOptima is also in the process of amending Windstone's current contract to stipulate its responsibilities for coordinating the care of OneCare members who receive outpatient mental health services through the County of Orange and its subcontracted providers.

Fiscal Impact
Payments for these programs during 2012 were less than $100,000. While increased volume is expected based on improved access, minimal financial impact is expected since the FFS payments to the County of Orange and its subcontracted providers is offset by the capitation rate change to Windstone.

Rationale for Recommendation
The proposed approach provides OneCare members with access to the most appropriate level of care in a manner that is seamless to them and based on their clinical need. Access to the Medi-Cal and MHSA-funded components provides OneCare members with the best opportunity for recovery, leading to the combined outcome of a healthier member and reduced system costs.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *3/29/2013*
Authorized Signature — **Date**

AMENDMENT VII

TO THE

COORDINATION AND PROVISION OF BEHAVIORAL HEALTHCARE SERVICES CONTRACT

THIS AMENDMENT VII is entered into by and between the Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima") and the County of Orange, a political subdivision of the State of California, through its division the **Orange County Health Care Agency**, ("County"), and shall become effective on the first day of the first month following execution of this Amendment VII by both parties (the "Effective Date"), with respect to the following facts:

RECITALS

A. CalOptima and County entered into a Coordination and Provision of Behavioral Healthcare Services Contract ("Contract"), effective September 1, 2013, whereby County agreed to provide Medicare behavioral health services to OneCare Members. The Contract was subsequently amended as follows: Amendment I, effective September 1, 2013, extended the Contract to cover Cal MediConnect (OneCare Connect) members; Amendment II, effective January 1, 2015, revised the commencement of Cal MediConnect, extended the Contract to December 31, 2017, and updated the Behavioral Health benefit matrix; Amendment III, effective January 1, 2018, extended the Contract to December 31, 2020, with an option to renew for two (2) additional one-year terms, and updated the Behavioral Health benefit matrix; Amendment IV, effective December 1, 2020, updated the Contract's terms and conditions to comply with Medicare regulatory requirements and to clarify the Contract's scope and compensation; Amendment V, effective December 1, 2020, renewed the Contract for one year, effective January 1, 2021 to December 31, 2021, and updated Addendum 2, Schedule 2, Coverage Matrix 2 to reflect responsibility for an Opioid Treatment Program under Medicare; and Amendment VI, effective October 1, 2021, updated the Contract to add PACE.

B. CalOptima and County now desire to renew this Contract for one year.

NOW, THEREFORE, the parties agree as follows:

1. This Contract is renewed for a period of one (1) year, effective January 1, 2022 through December 31, 2022.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment VII, all other conditions contained in the Contract as previously amended shall continue in full force and effect.

IN WITNESS WHEREOF, the Parties have executed this Amendment VII.

FOR COUNTY	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

Approved As To Form
County Counsel
County of Orange, California

By: _____
Deputy

Dated: _____

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

23. Consider Authorizing Extension of Ancillary Fee-for-Service Contracts for Non-Medical Transportation and Disposable Incontinence Supplies Providers

Contacts

Yunkyung Kim, Chief Operating Officer (714) 246-8408
Michelle Laughlin, Executive Director, Network Operations (657) 900-1116

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend ancillary fee-for-service (FFS) contracts for Non-Medical Transportation and Disposable Incontinence Supplies Providers for a one year period through December 31, 2022.

Background and Discussion

CalOptima periodically releases RFPs to recruit providers and vendors for medical and non-medical services for its members, including Non-Medical Transportation (NMT) and Disposable Incontinence Supplies (DIS). CalOptima utilizes the ancillary contract for these providers.

Through RFPs, CalOptima selected the ancillary providers listed below for a contract term effective January 1, 2018, for a period of three years, plus two additional one-year extension options with CalOptima Board of Directors (Board) approval. The initial three-year term for the following providers is set to expire on December 31, 2021, and all are eligible for an additional one-year extension upon Board approval:

- Veyo LLC (NMT)
- Shield – California Health Care Center, Inc. (DIS)
- Medline Industries Inc. (DIS)
- Schraders' Medical Supply Inc. (DIS)
- Caremax RM Corporation (DIS)
- Byram Healthcare Centers, Inc. (DIS)

These providers are part of a broad network of provider types that CalOptima maintains to support member health needs. Through annual audits, these providers have demonstrated that they are qualified and capable of meeting the needs of CalOptima members for NMT and DIS. Prior to the expiration of the one-year extension, staff will return to the Board with recommendations for a long-term contracting strategy for DIS providers. For NMT, Staff plan to conduct an RFP in 2022 and will return to the Board with recommendations based on the results of the RFP prior to the final one-year extension. To ensure continuity of access to NMT and DIS, staff recommends Board approval to exercise the first of two one-year extension options for each of these contracts, extending them through December 31, 2022

Fiscal Impact

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The recommended action to extend ancillary FFS contracts for the identified NMT and DIS providers through December 31, 2022, under the same terms and conditions, has no additional fiscal impact to the CalOptima Fiscal Year (FY) 2021-22 Operating Budget. Management will include funding for the period of July 1, 2022, through December 31, 2022, in the CalOptima FY 2022-23 Operating Budget.

Rationale for Recommendation

Approving the extension of ancillary FFS contracts for NMT and DIS will ensure members' continued access to needed supplies and services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action August 2, 2018: Consider Authorizing Contract with a Non-Medical Transportation (NMT) Vendor Effective January 1, 2019
3. Previous Board Action December 7, 2017: Consider Authorizing Extension of Disposable Incontinence Supplies (DIS) Contracts with Caremax RM Corporation, Schraders' Medical Supply, Inc., and Byram Healthcare Centers; Consider Authorizing Request for Proposal (RFP) Process

Board Actions

Board Meeting Dates	Action
December 7, 2017	Consider Authorizing Extension of Contract with American Logistics for Non-Medical Transportation Services
August 3, 2017	Consider Ratification of Amendment to Contract with American Logistics; Consider Actions Related to Implementing Medi-Cal Non-Medical Transportation Benefit
April 7, 2016	Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016
September 3, 2015	Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic
November 6, 2014	Authorize the Chief Executive Officer to Extend Existing Disposable Incontinence Supplies Contracts for an Additional Three Years

/s/ Richard Sanchez — *10/28/2021*

Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Byram Healthcare Centers, Inc.	5302 Rancho Rd.	Huntington Beach	CA	92647
Caremax RM Corporation	8271 Commonwealth Ave.	Buena Park	CA	90621
Medline Industries Inc.	1960 Miro Way	Rialto	CA	92376
Schraders' Medical Supply, Inc.	5507 Brooks St.	Montclair	CA	91763
Shield – California Health Care Center, Inc	27911 W. Franklin Pkwy.	Valencia	CA	91355
Veyo LLC	4875 Eastgate Mall	San Diego	CA	92121

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
11. Consider Authorizing Contract with a Non-Medical Transportation (NMT) Vendor Effective January 1, 2019

Contact
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into agreement with Veyo LLC to serve as CalOptima's Non-Medical Transportation Vendor for OneCare Connect, OneCare and Medi-Cal members, except those enrolled in Kaiser. Contract to be effective January 1, 2019 for a three (3) year term with two (2) additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
CalOptima has provided NMT services to Medicare beneficiaries through American Logistics Corporation (ALC) since 2008. This service was provided as a supplemental benefit to members of CalOptima's OneCare program, and upon its inception, to OneCare Connect members. On July 1, 2016, NMT benefits were extended to children accessing Early and Periodic Screening Diagnostic and Treatment (EPSDT) services through the Medi-Cal program. The contract with ALC was amended to include the additional benefit coverage.

On June 29, 2017, the California Department of Health care Services (DHCS) released All Plan Letter (APL) 17-010 providing Managed Care Plans (MCP) including CalOptima with guidance for Non-Emergency Medical Transportation and NMT services. The APL specified that, effective July 1, 2017, MCPs were expected to provide NMT services for all Medi-Cal members. These services include round trip transportation for medically necessary covered and carved-out Medi-Cal services. NMT services may be provided by passenger car, taxi cab, or any other form of public or private conveyance as well as gas mileage reimbursement under certain conditions.

On August 3, 2017, the CalOptima Board of Directors ratified an amendment to the ALC contract to provide the expanded benefit and authorized the CEO to issue a Request for Proposal (RFP) to solicit bids from vendors to provide NMT services for CalOptima members effective April 1, 2018.

On December 7, 2017, the Board authorized staff to extend the existing ALC contract through December 31, 2018. This extension allowed staff additional time to clarify operational concerns which was essential to drafting a comprehensive Scope of Work for the RFP and to assess the RFP responses to identify the provider for this service.

Discussion
The RFP was issued by CalOptima in December 2017 and included a Scope of Work and the CalOptima contract. Three qualified vendors participated and their responses to the RFP were

reviewed by CalOptima's evaluation team, which consisted of representatives from the following departments: Customer Service, Medical Management, Contracting, Finance, Claims Administration, Regulatory Affair and Compliance, and Information Services. The selected vendor will be obligated to coordinate the NMT transportation needs of all members. As such, the RFP responders were evaluated based on services provided, ability to manage administrative services which included eligibility verification, reporting, technical capabilities, interpreter services, claims administration and adequacy of vehicles. In addition, the three vendors underwent an interview process conducted by the evaluation team and were assessed based on their presentations and qualification.

The evaluation team's final weighted scoring for the RFP is as follows:

Vendor	Score
Veyo LLC	85.91
American Logistics Company, LLC	79.09
Access2Care, LLC	71.36

The RFP evaluation team identified Veyo LLC as the vendor that best meets CalOptima's need for a safe, reliable, regulatorily compliant, technologically advanced, and cost-effective transportation vendor. Accordingly, staff recommends contracting with Veyo, LLC for an initial three (3) year term with option to extend the contract for two (2) additional one-year terms.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes approximately $7.03 million for Medi-Cal, OneCare Connect, and OneCare non-medical transportation expenses. Based on projected utilization trends, the budgeted amount is expected to be sufficient to cover the costs of providing NMT services in FY 2018-19, under the proposed reimbursement terms with Veyo, LLC. Therefore, the recommended action to enter into agreement with Veyo, effective January 1, 2019, is a budgeted item with no expected additional fiscal impact.

Rationale for Recommendation

Based on the review of the possible vendors, Staff recommends contracting with Veyo, LLC to maintain compliance with NMT requirements and to ensure members receive safe, reliable transportation to covered services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated December 7, 2017, Consider Authorizing Extension of Contract with American Logistics for Non-Medical Transportation Services
    a. Board Action dated September 3, 2015, Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic
    b. Board Action dated April 7, 2016, Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016

c. Board Action dated August 3, 2017, Consider Ratification of Amendment to Contract with American Logistics; Consider Actions Related to Implementing Medi-Cal Non-Medical Transportation Benefit
d. July 17, 2017 DHCS ALL Plan Letter 17-010 (Revised) Non-Emergency Medical and Non-Medical Transportation Services

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
16. Consider Authorizing Extension of Contract with American Logistics for Non-Medical Transportation Services

Contact
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Action
Authorize the CEO, with the assistance of legal counsel, to amend CalOptima's contract with American Logistics for non-medical transportation (NMT) for CalOptima Medi-Cal members to extend this agreement through December 31, 2018. All other terms and conditions will remain the same.

Background/Discussion
Medi-Cal managed care plan (MCP) benefits include emergency transportation, non-emergency medical transportation (NEMT) and, prior to July 1, 2017, non-medical transportation (NMT) only for children accessing Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. However, AB 2394 (Garcia, 2016) amends the covered outpatient services delineated in Welfare & Institutions Code section 14312 to expressly include NMT for all Medi-Cal members, including adults, effective July 1, 2017, "subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services."

Prior to July 1, 2017, CalOptima contracted with American Logistics to provide taxi servcies for OneCare and OneCare Connect members, as well as Medi-Cal members receiving EPSDT services. The agreement with American Logistics covering transporation to and from EPSDT services was authorized by the CalOptima Board on September 3, 2015, with the contract covering Medicare services authorized by the Board on April 7, 2016 and executed on July 1, 2016. Considering the short lead time between the DHCS's issuance of APL 17-010 on June 29, 2017 and the required implementation date (the following day), CalOptima staff amended the American Logistics contract through March 31, 2018 to broaden the scope of work to include the Medi-Cal NMT benefit to ensure that the benefit was available to members while a longer term solution was being developed. This action was ratified by the Board at the August 3, 2017 meeting.

Also on August 3, 2017, the Board of Directors authorized staff to issue a RFP to solicit bids from vendors to provide NMT services for CalOptima Medi-Cal members with an effective date of April 1, 2018.

Staff is in the process of issuing a RFP. However, staff has determined that more time is needed to issue, assess and identify successful provider(s) to supply NMT services and to implement the services with providers. The Department of Health Care Services (DHCS) has indicated that a Dual Plan Letter will be issued to provide additional guidance regarding NMT services for Cal

MediConnect plans which has not been released yet. Additional information to address operational concerns has also been provided by DHCS, most recently on November 13, 2017. The enhanced information provided by the State has been instrumental in crafting a statement of work for the RFP. Consequentily, to allow sufficient time for the RFP process while all the updates from DHCS is being incorporated and ensure that there is no disruption to member access to this important transportation benefit, staff is requesteng Board authority to extend the American Logistics contract through December 31, 2018. It is anticipated that contract(s) with the vendor(s) selected through the RFP process will take effect on January 1, 2019.

Fiscal Impact

Because the NMT benefit was added by a DHCS APL 17-010 on June 29, 2017 and took effect the following day, funding for this mandated benefit was not included in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget. Based on draft capitation rates received from DHCS, projected costs for the NMT benefit are approximately $4.83 million for FY 2017-18. Staff anticipates that funding for NMT services will be sufficient to fully cover the costs of the benefit. Management plans to include expenses related to NMT services for the period July 1, 2018, through December 31, 2018, in the FY 2018-19 Operating Budget.

Rationale for Recommendation

CalOptima staff recommends extension of the current contract with American Logistics through December 2018 for NMT services to ensure that CalOptima Medi-Cal beneficiaries have access to this important benefit while the RFP process is being completed.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated September 3, 2015, Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Guidelines, Conduct a Request for Proposal Process for Taxi Services, and Contract with Selected Vendor(s)
2. Board Action dated April 7, 2016, Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016
3. Board Action dated August 3, 2017, Consider Ratification of Amendment to Contract with American Logistics; Consider Actions Related to Implementing Medi-Cal Non-Medical Transportation Benefit
    a. July 17, 2017 DHCS All Plan Letter 17-010 (Revised) Non-Emergency Medical and Non-Medical Transportation Services

/s/ Michael Schrader — *11/30/2017*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 3, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. F. Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Guidelines, Conduct a Request for Proposal Process for Taxi Services, and Contract with Selected Vendor(s)

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Extend current OneCare/OneCare Connect taxi services contract for an additional six months from January 1, 2016 through June 30, 2016;
2. Amend budget based on Department of Health Care Services (DHCS) requirements for taxi services for qualifying Medi-Cal children and their caregiver and/or guardian per 2015 EPSDT guidelines for the 2015-2016 fiscal year;
3. Amend contracts with existing taxi services providers to include the Medi-Cal program EPSDT benefit; and
4. Issue a Request for Proposal (RFP) for taxi services for the OneCare, OneCare Connect and Medi-Cal lines of business, and authorize the CEO to contract with vendor(s) selected through this process, with contracts to be effective July 1, 2016 for a two-year term, with three additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background and Discussion

Taxi transportation is a supplemental benefit for OneCare (OC) and a required benefit for OneCare Connect (OCC) members. CalOptima has contracted with American Logistics since January 1, 2008 for services to OneCare members, as a result of an RFP process was conducted in 2007. At its November 6, 2008 meeting, the Board authorized CalOptima's OC Taxi Transportation supplemental benefit, including extension of CalOptima's contract with American Logistics. At its January 2013 meeting, the Board authorized staff to leverage the OC provider network as the basis for the Duals Delivery system, and OCC was added to the current OC contract. The current contract expires December 31, 2015, based on the previous contract extensions.

Currently, the OC and OCC benefits allow for thirty (30) one-way trips per calendar year for each Member. To access this benefit, Members call American Logistics directly and schedule their taxi pick-up in order to receive one-way transportation to their appointment. This is an important benefit for dual eligible beneficiaries, for many of whom availability of transportation may determine whether they are able to obtain appropriate medical services.

The Department of Health Care Services (DHCS), through the EPSDT guidance, requires that non-medical transportation via taxi be made available to qualifying children in the Medi-Cal program. Based on projected membership and expected cost per member per month (PMPM) for Fiscal Year (FY) 2015-16, a budget of $200,000 is requested to meet this requirement, and CalOptima's current

contract with the taxi provider for OneCare and OneCare Connect are to be amended to include Medi-Cal for the qualifying EPSDT children.
As mentioned above, American Logistics has been the sole taxi provider contracted January 1, 2008 as a result of an RFQ released in 2007. In accordance with vendor management best practices, it is appropriate to complete a new RFP process, with the targeted effective date of new contract(s) of July 1, 2016.

CalOptima's Medical Management and Customer Service staff have reviewed the utilization performance of this provider, evaluated the access needs of CalOptima members, and determined that American Logistics adequately meets CalOptima's requirements for the extended contract period. The extension is requested to allow for an appropriate time frame to complete an RFP process and review all candidates. Therefore, staff recommends extending the current contract for an additional six months, through June 30, 2015.

Fiscal Impact
Based on forecasted OneCare and OneCare Connect enrollment for FY 2015-2016, the fiscal impact of the recommended action to extend the existing OneCare/OneCare Connect taxi services contract for an additional six months from January 1, 2016, through June 30, 2016, is approximately $2,709,863. The recommended action is a budgeted item under the CalOptima FY 2015-16 Operating Budget approved by the Board on June 4, 2015.

Based on projected membership and expected cost PMPM for qualifying Medi-Cal children enrollment for FY 2015-16, the fiscal impact of the recommended action is expected to be approximately $200,000. This is an unbudgeted item. Funding for this recommended action is expected to be available from anticipated increase in net assets in the current fiscal year.

Rationale for Recommendation
CalOptima staff recommends authorizing an extension to the contract with American Logistics for six months to ensure that OneCare and OneCare Connect members continue to have access to covered services, authorize budget and contract amendment as soon as possible for EPSDT requirement per DHCS, and issuing an RFP for a taxi services effective July 1, 2016 to ensure that members have access to taxi services prospectively.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *8/28/2015*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016

Contact
Javier Sanchez, Chief Network Officer (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with American Logistics to serve as CalOptima's Taxi Vendor for OneCare Connect, OneCare, and Medi-Cal EPSDT members effective July 1, 2016, for a two (2) year term with three (3) additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current taxi services contract for CalOptima's Medicare programs has been in place since January 1, 2008. It was awarded to American Logistics through a competitive procurement process. The agreement expires on June 30, 2016.

On September 3, 2015, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for Taxi services for the contract period commencing July 1, 2016.

Following CalOptima's standard RFP process, an RFP was issued and a total of three responses were received.

Discussion
The responses to the RFP were reviewed by CalOptima's evaluation team consisting of the Senior Program Manager for Medicare, Customer Service Director, Customer Service Manager, Executive Director Medical Operations, Contracts Manager, and representatives from the following departments: Finance, Compliance, and Information Services. All vendors were provided a Scope of Work document and the CalOptima base contract at the time of the RFP.

The evaluation team's final weighted scoring for the RFP is as follows:

Vendor	Score
American Logistics	3.96
Access2Care	3.66
Veyo	3.19

Based upon the weighted scores each vendor received, American Logistics finished with the highest score at 3.96 out of a possible 5.0 of the evaluation. Access2Care finished second with a score of 3.66.

American Logistics was the only bidder who proved to have an established transportation network in the Orange County service area.

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Fiscal Impact
Under the terms of the proposed contract, consolidated taxi expenses are projected to decrease 4.9% in the next fiscal year. Management will include expenses associated with the proposed contract in the CalOptima FY 2016-17 operating budgets.

Rationale for Recommendation
CalOptima staff believes that contracting with the highest scoring taxi vendor, American Logistics, will meet the goal of continuing to ensure that CalOptima members receive safe, reliable transportation services in a cost-effective manner. CalOptima staff reviewed qualified taxi vendor responses and identified the candidate believed to best meet CalOptima's needs for safe, reliable, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with the existing taxi vendor as a result of completion of the RFP process authorized by the Board in September, 2015.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *04/01/2016*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

3. Consider Ratification of Amendment to Contract with American Logistics; Consider Actions Related to Implementing Medi-Cal Non-Medical Transportation Benefit

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Ratify amendment to contract with American Logistics expanding the scope of work to include the Medi-Cal covered taxi services benefit, excluding services provided for members assigned to Kaiser Permanente, for nine months beginning July 1, 2017;
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend other existing contracts through no later than March 31, 2018 as necessary to ensure that qualifying Medi-Cal members have access to covered non-medical transportation services; and
3. Authorize the CEO to conduct a Request for Proposal (RFP) process to solicit bids from vendors providing non-medical transportation for CalOptima Medi-Cal, effective April 1, 2018.

Background

Medi-Cal managed care plan (MCP) benefits include emergency transportation, non-emergency medical transportation (NEMT) and, prior to July 1, 2017, non-medical transportation (NMT) only for children accessing Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. However, AB 2394 (Garcia, 2016) amends the covered outpatient services delineated in Welfare & Institutions Code section 14312 to expressly include NMT for all Medi-Cal members, including adults, effective July 1, 2017, "subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services."

On June 29, 2017, the California Department of Health Care Services (DHCS) released All Plan Letter (APL) 17-010 providing MCPs with guidance for NEMT and NMT. Per the APL, beginning July 1, 2017, MCPs were expected to update their NEMT policy and procedures and begin providing NMT for all Medi-Cal members. NMT services include round trip transportation for medically necessary covered and carved-out Medi-Cal services. MCPs are required to provide NMT by passenger car, taxicab, or any other form of public or private conveyance (including private vehicle), as well as gas mileage reimbursement under certain conditions.

Transportation must be physically and geographically accessible and consistent with disability rights laws. One attendant, such as a parent, spouse or guardian may accompany the member. Additionally, a minor can travel without a parent for services which do not require parental consent and otherwise with parental consent.

Prior authorization may, at the discreation of the MCP, be required and reauthorized every 12 months when necessary. When applicable, the MCP is responsible for ensuring that parental consent is obtained in advance of arranging transportation. For NMT requests by private conveyance (e.g.,

family members, friends, neighbors, etc.), members must attest, in person, by phone, or electronically, that no other methods of transporation are reasonably available and alternatives have been reasonably exhausted. The attestation may include confirmation that the member:

- Has no valid driver's license;
- No working vehicle available in the household;
- Is unable to travel or wait for medical or dental services alone; or
- Has a physical, cognitvie, mental, or developmental limitation.

Reimbursement for private conveyance includes only mileage at the Internal Revenue Service (IRS) standard mileage rates for medical purposes (the 2017 reimbursement rate is $0.17 per mile) and can be made only for drivers compliant with California driving requirements, which includes a valid driver's license, vehicle registration and vehicle insurance. Neither the legislation nor the APL establish any additional specific requirements or criteria for driver eligibility.

Prior to July 1, 2017, CalOptima contracted with American Logistics to provide taxi servcies for OneCare and OneCare Connect members, as well as Medi-Cal members receiving EPSDT services. The agreement with American Logistics covering transporation to and from EPSDT services was authorized by the CalOptima Board on September 3, 2015, with the contract covering Medicare services authorized by the Board on April 7, 2016 and executed on July 1, 2016. Considering the short lead time between the DHCS's issuance of APL 17-010 on June 29, 2017 and the required implementation date (the following day), CalOptima staff amended the American Logistics contract on a short term basis to broaden the scope of work to include the Medi-Cal NMT benefit to ensure that the benefit was available to members while a longer term solution was being developed.

Discussion

CalOptima staff leveraged an existing transportation contract to ensure that the effective date for the new NMT requirement was met. On July 1, 2017, CalOptima began providing the expanded NMT services including the amended contract with American Logistics, as well as via taxi, bus, and private conveyance arranged by members. This benefit is separate from other existing transportation benefits, and members can continue to access emergency and NEMT services in accordance with existing processes. To access NMT services, members can contact CalOptima's Customer Service Department to discuss and coordinate transportation.

Should all other reasonable transportation options be exhausted and private conveyance be required, CalOptima's Customer Service Department will issue a reference number, and members can arrange for their own transportation, with their private drivers submitting gas mileage receipts for reimbursement to CalOptima. In order to receive reimbursement, private drivers will also be required to submit proof that they meet California driving requirements which include valid driver's license, vehicle registration, and evidence of vehicle insurance.

In order to ensure that qualifying Medi-Cal members have access to public conveyance options, bus and taxi services are being offered. CalOptima will continue to procure passes from the Orange County Transit Authority (OCTA) for both bus and OC ACCESS, for members who are unable to use regular bus service due to functional limitations caused by a disability. For taxi services, the

scope of work of the current contract with American Logistics (CalOptima's contracted provider for OneCare and OneCare Connect) has been amended through March 31, 2018 as a short term measure to ensure that this transportation benefit is available to Medi-Cal members.

During this nine month period, CalOptima staff will consider longer term options for providing the NMT benefit and conduct an RFP to identify potential vendors and return to the Board with the RFP results and recommendations. In addition, staff is in the process of developing a comprehensive transportation program, and will be returning to the Board with recommendations and policy updates.

Fiscal Impact
The recommended action to ratify the amendment to the American Logistics contract, amend contracts with existing providers, and conduct an RFP process is expected to result in an increase in both claims and administration expense for CalOptima. However, because non-medical transportation is a newly-mandated benefit and since no projected utilization data has been provided by DHCS, the fiscal impact of this benefit is not currently known. CalOptima staff will continue to work with DHCS to ensure that funding for non-medical transportation will be appropriate and sufficient to fully cover the costs of the benefit. On a prospective basis, staff will update the Board as appropriate on the expenses associated with providing this benefit. Long term, staff anticipates that the program will be budget neutral to CalOptima.

Rationale for Recommendation
CalOptima staff recommends the above actions in order to be compliant with the NMT requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated September 3, 2015, Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Guidelines, Conduct a Request for Proposal Process for Taxi Services, and Contract with Selected Vendor(s)
2. Board Action dated April 7, 2016, Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016
3. July 17, 2017 DHCS All Plan Letter 17-010 (Revised) Non-Emergency Medical and Non-Medical Transportation Services

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: July 17, 2017

ALL PLAN LETTER 17-010 (*REVISED)*

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: NON-EMERGENCY MEDICAL AND NON-MEDICAL TRANSPORTATION SERVICES

PURPOSE:
This All Plan Letter (APL) provides Medi-Cal managed care health plans (MCPs) with guidance regarding Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services. With the passage of Assembly Bill (AB) 2394 (Chapter 615, Statutes of 2016), which amended Section 14132 of the Welfare and Institutions Code (WIC), the Department of Health Care Services (DHCS) is clarifying MCPs' obligations to provide and coordinate NEMT and NMT services. In addition, this APL provides guidance on the application of NEMT and NMT services due to the Medicaid Mental Health Parity Final Rule (CMS-2333-F)[1]. *Revised text is found in italics.*

BACKGROUND:
DHCS administers the Medi-Cal Program, which provides comprehensive health care services to millions of low-income families and individuals through contracts with MCPs. Pursuant to Social Security Act (SSA) Section 1905(a)(29) and Title 42 of the Code of Federal Regulations (CFR) Sections 440.170, 441.62, and 431.53, MCPs are required to establish procedures for the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for qualifying members to receive medically necessary transportation services. NEMT services are authorized under SSA Section 1902 (a)(70), 42 CFR Section 440.170, and Title 22 of the California Code of Regulations (CCR) Sections 51323, 51231.1, and 51231.2.

AB 2394 amended WIC Section 14132(ad)(1) to provide that, effective July 1, 2017, NMT is covered, subject to utilization controls and permissible time and distance standards, for MCP members to obtain covered Medi-Cal medical, dental, mental health, and substance use disorder services. Beginning on July 1, 2017, MCPs must provide NMT for MCP members to obtain medically necessary MCP-covered services and must make their best effort to refer for and coordinate NMT for all Medi-Cal services

[1] CMS-2333-F

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
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not covered under the MCP contract. Effective October 1, 2017, in part to comply with CMS-2333-F and to have a uniform delivery system, MCPs must also provide NMT for Medi-Cal services that are not covered under the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other services delivered through the Medi-Cal fee-for-service (FFS) delivery system.

REQUIREMENTS:

Non-Emergency Medical Transportation
NEMT services are a covered Medi-Cal benefit when a member needs to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist, or mental health or substance use disorder provider. NEMT services are subject to a prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care facility licensed pursuant to Health and Safety Code (HSC) Section 1250[2].

MCPs must ensure that the medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with their contract with DHCS[3]. MCPs are also required to authorize, at a minimum, the lowest cost type of NEMT transportation (see modalities below) that is adequate for the member's medical needs. For Medi-Cal services that are not covered by the MCP's contract, the MCP must make its best effort to refer for and coordinate NEMT. MCPs must ensure that there are no limits to receiving NEMT as long as the member's medical services are medically necessary and the NEMT has prior authorization.

MCPs are required to provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services[4]. MCPs are required to provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches[5]. MCPs shall also ensure door-to-door assistance for all members receiving NEMT services.

Unless otherwise provided by law, MCPs must provide transportation for a parent or a guardian when the member is a minor. With the written consent of a parent or guardian, MCPs may arrange NEMT for a minor who is unaccompanied by a parent or a guardian.

[2] 22 CCR Section 51323 (b)(2)(C)
[3] Exhibit A, Attachment 1 (Organization and Administration of the Plan)
[4] 22 CCR Section 51323 (a)
[5] Manual of Criteria for Medi-Cal Authorization, Chapter 12.1 Criteria for Medical Transportation and Related Services

MCPs must provide transportation services for unaccompanied minors when applicable State or federal law does not require parental consent for the minor's service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.

MCPs must provide the following four available modalities of NEMT transportation in accordance with the Medi-Cal Provider Manual[6] and the CCR[7] when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care:

1. MCPs must provide **NEMT ambulance services** for[8]:
    - Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation.
    - Transfers from an acute care facility to another acute care facility.
    - Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
    - Transport for members with chronic conditions who require oxygen if monitoring is required.

2. MCPs must provide **litter van services** when the member's medical and physical condition does not meet the need for NEMT ambulance services, but meets both of the following:
    - Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport[9].
    - Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance[10].

3. MCPs must provide **wheelchair van services** when the member's medical and physical condition does not meet the need for litter van services, but meets any of the following:
    - Renders the member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport[11].

[6] Medi-Cal Provider Manual: Medical Transportation – Ground
[7] 22 CCR Section 51323(a) and (c)
[8] Medi-Cal Provider Manual: Medical Transportation – Ground, page 9, Ambulance: Qualified Recipients
[9] 22 CCR Section 51323 (2)(A)(1)
[10] 22 CCR Section 51323 (2)(B)
[11] 22 CCR Section 51323 (3)(A)

- Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation[12].
- Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance[13].

Members with the following conditions may qualify for wheelchair van transport when their providers submit a signed Physician Certification Statement (PCS) form (as described below)[14]:

- Members who suffer from severe mental confusion.
- Members with paraplegia.
- Dialysis recipients.
- Members with chronic conditions who require oxygen but do not require monitoring.

4. MCPs must provide **NEMT by air** only under the following conditions[15]:
   - When transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist, or mental health or substance use disorder provider.

NEMT Physician Certification Statement Forms

MCPs and transportation brokers must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, the MCP cannot modify the authorization. In order to ensure consistency amongst all MCPs, all NEMT PCS forms must include, at a minimum, the components listed below:

- Function Limitations Justification: For NEMT, the physician is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate *without* assistance or be transported by public or private vehicles.
- Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
- Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance/gurney van, litter van, wheelchair van or air transport).

[12] 22 CCR Section 51323 (3)(B)
[13] 22 CCR Section 51323 (3)(C)
[14] Medi-Cal Provider Manual: Medical Transportation – Ground, page 11, Wheelchair Van
[15] 22 CCR Section 51323 (c)(2)

- Certification Statement: Prescribing physician's statement certifying that medical necessity was used to determine the type of transportation being requested.

Each MCP must have a mechanism to capture and submit data from the PCS form to DHCS. Members can request a PCS form from their physician by telephone, electronically, in person, or by another method established by the MCP.

Non-Medical Transportation
NMT has been a covered benefit when provided as an EPSDT service[16]. Beginning on July 1, 2017, MCPs must provide NMT for MCP members to obtain medically necessary MCP-covered services. For all Medi-Cal services not covered under the MCP contract, MCPs must make their best effort to refer for and coordinate NMT.

Effective October 1, 2017, MCPs must provide NMT for all Medi-Cal services, including those not covered by the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system.

NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. Physicians may authorize NMT for members if they are currently using a wheelchair but the limitation is such that the member is able to ambulate without assistance from the driver. The NMT requested must be the least costly method of transportation that meets the member's needs.

MCPs are contractually required to provide members with a Member Services Guide that includes information on the procedures for obtaining NMT transportation services[17]. The Member Services Guide must include a description of NMT services and the conditions under which NMT is available.

At a minimum, MCPs must provide the following NMT services[18]:

- Round trip transportation for a member by passenger car, taxicab, or any other form of public or private conveyance (private vehicle)[19], as well as mileage reimbursement for medical purposes[20] when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.

[16] WIC 14132 (ad)(7)
[17] Exhibit A, Attachment 13 (Member Services), Written Member Information
[18] WIC Section 14132(ad)
[19] Vehicle Code (VEH) Section 465
[20] IRS Standard Mileage Rate for Business and Medical Purposes

- Round trip NMT is available for the following:
    - Medically necessary covered services.
    - Members picking up drug prescriptions that cannot be mailed directly to the member.
    - Members picking up medical supplies, prosthetics, orthotics and other equipment.
- MCPs must provide NMT in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

Conditions for Non-Medical Transportation Services:

- MCP may use prior authorization processes for approving NMT services and re-authorize services every 12 months when necessary.
- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of initial NMT authorization request.
- With the written consent of a parent or guardian, MCPs may arrange for NMT for a minor who is unaccompanied by a parent or a guardian. MCPs must provide transportation services for unaccompanied minors when state or federal law does not require parental consent for the minor's service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.
- NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.
- For private conveyance, the member must attest to the MCP in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
    - Has no valid driver's license.
    - Has no working vehicle available in the household.
    - Is unable to travel or wait for medical or dental services alone.
    - Has a physical, cognitive, mental, or developmental limitation.

Non-Medical Transportation Private Vehicle Authorization Requirements

The MCPs must authorize the use of private conveyance (private vehicle)[21] when no other methods of transportation are reasonably available to the member or provided by the MCP. Prior to receiving approval for use of a private vehicle, the member must exhaust all other reasonable options and provide an attestation to the MCP stating other methods of transportation are not available. The attestation can be made over the

[21] VEH Section 465

phone, electronically, or in person. In order to receive gas mileage reimbursement for use of a private vehicle, the driver must be compliant with all California driving requirements, which include[22]:

- Valid driver's license.
- Valid vehicle registration.
- Valid vehicle insurance.

MCPs are only required to reimburse the driver for gas mileage consistent with the Internal Revenue Service standard mileage rate for medical transportation[23].

Non-Medical Transportation Authorization

MCPs may authorize NMT for each member prior to the member using NMT services. If the MCP requires prior authorization for NMT services, the MCP is responsible for developing a process to ensure that members can request authorization and be approved for NMT in a timely matter. The MCP's prior authorization process must be consistently applied to medical/surgical, mental health and substance use disorder services as required by CMS-2333-F.

Non-Medical Transportation and Non-Emergency Medical Transportation Access Standards

MCPs are contractually required to meet timely access standards[24]. MCPs that have a Knox-Keene license are also required to meet the timely access standards contained in Title 28 CCR Section 1300.67.2.2. The member's need for NMT and NEMT services do not relieve the MCPs from complying with their timely access standard obligations.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contractual requirements, and other requirements set forth in DHCS guidance, including APLs and Dual Plan Letters. MCPs must timely communicate these requirements to all delegated entities and subcontractors in order to ensure compliance.

[22] VEH Section 12500, 4000, and 16020
[23] IRS Standard Mileage Rate for Business and Medical Purposes
[24] 28 CCR Section1300.51(d)(H); Exhibit A, Attachment 9 (Access and Availability)

If you have any questions regarding this APL, contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorizing Extension of Disposable Incontinence Supplies (DIS) Contracts with Caremax RM Corporation, Schraders' Medical Supply, Inc., and Byram Healthcare Centers; Consider Authorizing Request for Proposal (RFP) Process

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to extend the existing Disposable Incontinence Supplies (DIS) contracts expiring December 31, 2017, with Caremax RM Corporation, Schraders' Medical Supply, Inc., and Byram Healthcare Centers for a one (1) year period; and
2. Authorize the CEO to complete a Request for Proposal (RFP) process for DIS and to select and contract with vendor(s) selected via the RFP process effective January 1, 2019.

Background

Disposable Incontinence Supplies (subject to utilization controls) are covered benefits under the Medi-Cal program and are CalOptima's financial responsibility for CalOptima Direct (COD) members. These supplies include, but are not limited to, disposable diapers and briefs, liners and underpads. The three current providers were contracted through the competitive procurement process in 2009, and the contracts took effect on January 1, 2010. The contracts with extension options, expired on December 31, 2014. Board action taken November 6, 2014 extended the contracts for three additional years through December 31, 2017. Upon review of the performance of the existing vendors, staff has determined that the existing providers are sufficient to meet the current needs of CalOptima members and will continue to be sufficient for the next year.

Due to the time that has elapsed since the last RFP for DIS in 2009, staff recommends that a new RFP be issued for DIS. Therefore, management recommends that the Board authorize extension of the current DIS contracts for a one-year period under the same terms and conditions while staff conducts a competitive procurement process for DIS.

The renewal of the contracts with existing providers will support the stability of CalOptima's contracted provider network and ensure consistent delivery of disposable incontinence supplies. Contract language does not guarantee any provider any particular volume or exclusivity, and allows for CalOptima and the providers to terminate the contracts with or without cause.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2017-18 Operating Budget approved by the Board on June 1, 2017, included approximately $3.9M in expenses related to incontinence supplies. Since rates and terms of the existing contracts for incontinence supplies will remain unchanged through the extension period,

the recommended action to extend current contracts with incontinence supply providers from January 1, 2018, through June 30, 2018, is a budgeted item with no additional fiscal impact. Management will include expenses related to incontinence supplies for the period July 1, 2018, through December 31, 2018, in the FY 2018-19 Operating Budget.

Rationale for Recommendation

CalOptima staff recommends authorizing the extension of existing contracts with Disposable Incontinence Supplies providers to maintain the current effective provider network and meet member needs while an RFP process is being conducted.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Board Action dated November 6, 2014, Authorize the Chief Executive Officer to Extend Existing Disposable Incontinence Supplies Contracts for an Additional Three Years

/s/ Michael Schrader — *11/30/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 6, 2014
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

VI. D. Authorize the Chief Executive Officer (CEO) to Extend Existing Disposable Incontinence Supplies Contracts for an Additional Three Years

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Action

Authorize the CEO to extend existing disposable incontinence supplies contracts expiring December 31, 2014, for an additional 3-year period ending December 31, 2017.

Background/Discussion

Disposable incontinence supplies are a covered benefit under the Medi-Cal program and are CalOptima's financial responsibility for CalOptima Direct (COD) members. These supplies include disposable diapers and briefs, liners and underpads, and related items. The three current providers of these supplies to CalOptima members were awarded contracts based on a competitive procurement process in 2009, and the contracts took effect on January 1, 2010. These contracts, including all extension options, expire December 31, 2014.

Upon review of the performance of the existing vendors, staff determined that the existing providers are sufficient to meet the current needs of CalOptima members. Therefore, management recommends that the Board authorize extension of the current disposable incontinence supplies contracts for a three-year period under the same terms and conditions.

The renewal of the contracts with existing providers will support the stability of CalOptima's contracted provider network and ensure consistent delivery of disposable incontinence supplies. The Board of Directors will continue to preside over contract directives and renewals. Contract language does not guarantee any provider any particular volume or exclusivity, and allows for CalOptima and the providers to terminate the contracts with or without cause.

Fiscal Impact

The recommended action is budget neutral, with no material fiscal impact anticipated to CalOptima.

Rationale for Recommendation

CalOptima staff recommends authorizing the extension of existing contracts with disposable incontinence supplies providers to maintain the current effective provider network and meet member needs.

Concurrence

Gary Crockett, Chief Counsel

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Attachments
None

/s/ Michael Schrader *10/31/2014*
Authorized Signature **Date**

CalOptima Board Action Agenda Referral

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

24. Consider Authorizing Amendments to the Kindred Healthcare Fee-for-Service Hospital Contracts to Increase Rates for Medi-Cal Members

Contacts

Yunkyung Kim, Chief Operating Officer 714-246-8408
Michelle Laughlin, Executive Director Network Operations 657-900-1116

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the Kindred Healthcare Fee-for-Service (FFS) hospital contract Medi-Cal reimbursement rates effective November 1, 2021, as follows:
    a. Adjust the Medi-Cal inpatient per-diem rate structure to reflect an aggregate increase of 11.6%, and increase rates for outpatient services other than hospital-administered drugs; and
    b. Reflect updated Medi-Cal reimbursement for outpatient hospital-administered drugs.
2. Authorize unbudgeted expenditures in an amount up to $660,000 from existing reserves to fund the rate adjustment through June 30, 2022.

Background and Discussion

CalOptima currently contracts on a fee-for-service basis with hospitals to provide services to Medi-Cal, OneCare, and OneCare Connect members assigned to CalOptima Direct and Shared Risk groups, as well as PACE members. CalOptima's hospital network is comprised of both short-term and long-term acute care (LTAC) providers. In a June 2021 Board action, Medi-Cal FFS rates for contracted, short-term acute care hospitals were increased. Staff recommends an aggregate increase for its LTAC hospital provider, Kindred. As the sole LTAC service provider in Orange County, Kindred's services are vital to CalOptima members and the hospital network, and Kindred hospitals play a vital role in the community. Updated language will reflect these changes, as follows:

- Adjustment of the per-diem rate structure to reflect an aggregate increase of 11.6%.
-
- Medi-Cal reimbursement rates for outpatient services other than hospital-administered drugs reimbursed at 140% of the Medi-Cal fee schedule.
- Medi-Cal reimbursement rates for outpatient hospital-administered drugs at 100% of the Medi-Cal fee schedule. This change aligns with the Department of Health Care Services efficiency standards that will be applied for pharmacy in the upcoming year.

CalOptima will maintain Kindred's current per diem schedule for OC, OCC, and PACE. Without LTACs, short-term acute care hospitals would be impacted by a significant increase in long-term care patient stays, that would reduce access to acute care beds. To ensure continuity of access and support the stability of CalOptima FFS LTAC services for Medi-Cal members, staff requests approval of proposed amendments through June 30, 2022.

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Fiscal Impact

The recommended action to amend the Kindred Healthcare FFS hospital contract Medi-Cal reimbursement rates is unbudgeted. The annual net fiscal impact is projected to be approximately $984,000 or an 11.6% increase in medical expenses. An allocation of up to $660,000 from existing reserves will fund this action through June 30, 2022.

Rationale for Recommendation

Approving the rate increase to Kindred will continue to ensure the stability of CalOptima's FFS hospital network, and Medi-Cal member access to long-term acute care services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action June 3, 2021 "Consider Authorizing Extension and Amendments of the Fee-for-Service Hospital Contracts for Medi-Cal, OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly"
3. Previous Board Action April 2, 2020 "Consider Actions Related to the Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service Hospital Contracts
4. Proposed Fee-for-Service Hospital Contract Amendment

/s/ Richard Sanchez — *10/28/2021*

Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
THC – Orange County LLC, dba Kindred Hospital Brea	875 N. Brea Blvd.	Brea	CA	92821
THC – Orange County LLC, dba Kindred Hospital Westminster	200 Hospital Circle	Westminster	CA	92683
Southern California Specialty Care LLC dba Kindred Hospital – La Mirada	14900 E. Imperial Hwy.	La Mirada	CA	90638
Southern California Specialty Care LLC dba Kindred Hospital – Santa Ana	1901 N. College Ave.	Santa Ana	CA	92706

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

Recommended Actions
Authorize the Chief Executive Officer (CEO) to extend the terms of existing CalOptima Fee-for-Service (FFS), hospital contracts through June 30, 2022, and, with the assistance of Legal Counsel, to enter into amendments of those contracts to:

1. Standardize reimbursement rates for Medicare-based programs OneCare (OC), OneCare Connect (OCC), and Program of All-Inclusive Care for the Elderly (PACE);
2. Reflect updated Medi-Cal reimbursement for contracted FFS hospitals' All Patients Refined-Diagnosis Related Groups (APR-DRG) and blended per diem-based schedule, as applicable;
3. Reflect updated Medi-Cal reimbursement rates for contracted FFS hospital outpatient services, other than hospital-administered drugs; and
4. Reflect updated Medi-Cal reimbursement for outpatient hospital-administered drugs.

Background/Discussion
CalOptima currently contracts on a fee-for-service basis with hospitals to provide services to Medi-Cal, OneCare, OneCare Connect Members assigned to CalOptima Direct and Shared Risk groups, as well as PACE members. These hospital contracts extend on an annual basis, contingent upon approval from the CalOptima Board of Directors.

Current contracts with all FFS hospitals expire on June 30, 2021. Staff seeks to extend all existing FFS hospital contracts until June 30, 2022 and amend per the terms below. The proposed amendments include:

- In an effort to standardize rates, language will be added to reflect reimbursement rates for Medicare-based programs OC, OCC and PACE contracts at 100% of the Medicare Allowable pricing for all contracted FFS hospitals.

- Medi-Cal reimbursement rates for contracted acute care hospitals will be increased from 108% to 112% of APR-DRG for Inpatient Classic members and an equivalent increase will be applied to contracted FFS hospitals that remain with a per diem fee schedule. This does not apply to long-term acute care facilities. The increase aligns with CalOptima's focus on adjusting certain service categories, as needed, to ensure member access to quality care and network adequacy post COVID-19 pandemic.

- Medi-Cal reimbursement rates for contracted hospital outpatient services, other than hospital-administered drugs will be increased from 133% to 140% of the Medi-Cal Fee Schedule. This increase aligns with CalOptima's focus on adjusting certain service categories, as needed, to ensure member access to quality care and network adequacy post COVID-19 pandemic.

- Medi-Cal reimbursement rates for outpatient hospital administered drugs will be decreased from 133% to 100% of the Medi-Cal Fee Schedule. This change aligns with the Department of Health Care Services efficiency standards that will be applied for pharmacy in the upcoming year.

To ensure continuity of access to care and support the stability of CalOptima's contracted FFS hospital network for all Medi-Cal, OC, OCC and PACE members, staff requests approval of all proposed amendments for all contracted FFS hospitals and extension of contracts through June 30, 2022.

Fiscal Impact
Management has included costs associated with CalOptima FFS hospital contracts in the proposed CalOptima Fiscal Year (FY) 2021-22 Operating Budget pending Board approval. The annual fiscal impact of the proposed rate changes are as follows:

Medi-Cal program

- 3.75% increase to inpatient hospital rates are projected to increase hospital claims expenses by $4.1 million per year;
- 5.2% increase to outpatient hospital non-drug rate from 133% to 140% of the Medi-Cal fee schedule is projected to increase hospital claims expense by $2.9 million per year; and
- 24.8% reduction to outpatient hospital administered drugs is projected to decrease hospital claims expense by $4.0 million per year.

OneCare Connect, OneCare, PACE programs: 1.35% increase to inpatient hospital rates are projected to increase hospital claims expenses by $492,000 per year.

Rationale for Recommendation
CalOptima staff recommends this action to support the stability of CalOptima's contracted FFS hospital network, maintain and continue the contractual relationship with the hospital network and to fulfill regulatory requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. Medi-Cal Full-Risk HMO, SRG, and PHC Health Network Contract Amendment Template
3. Medi-Cal, OneCare, OneCare Connect and PACE FFS Hospital Contract Template

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

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Anaheim Global Medical Center	1025 S Anaheim Blvd	Anaheim	CA	92805
Anaheim Regional Medical Center	1111 W La Palma Ave	Anaheim	CA	92801
Chapman Global Medical Center	2601 E Chapman Ave	Orange	CA	92869
Childrens Hospital of Los Angeles	4650 W Sunset Blvd MS 87	Los Angeles	CA	90027
Children's Hospital of Orange County	1201 W La Veta Ave	Orange	CA	92868
CHOC Children's at Mission Hospital	27700 Medical Center Rd	Mission Viejo	CA	92691
College Hospital - Cerritos	10802 College Place	Cerritos	CA	90703
College Hospital Costa Mesa	301 Victoria St	Costa Mesa	CA	92627
Encompass Health Rehabilitation Hospital of Tustin	14851 Yorba St	Tustin	CA	92780
Foothill Regional Medical Center	14662 Newport Ave	Tustin	CA	92780
Fountain Valley Regional Hospital & Medical Center	17100 Euclid St	Fountain Valley	CA	92708
Garden Grove Hospital Medical Center	12601 Garden Grove Blvd	Garden Grove	CA	92843
HealthBridge Children's Hospital - Orange	393 S Tustin St	Orange	CA	92866
Hoag Memorial Hospital Presbyterian	1 Hoag Dr	Newport Beach	CA	92663
Hoag Memorial Hospital Presbyterian	16200 San Canyon Ave	Irvine	CA	92618
Huntington Beach Hospital	17772 Beach Blvd	Huntington Beach	CA	92647
Keck Medical Center of USC	1500 San Pablo St	Los Angeles	CA	90033
Kindred Hospital - Brea	875 N Brea Blvd	Brea	CA	92821
Kindred Hospital - La Mirada	14900 E Imperial Hwy	La Mirada	CA	90638
Kindred Hospital - Santa Ana	1901 N College Ave	Santa Ana	CA	92706
Kindred Hospital - Westminster	200 Hospital Circle	Westminster	CA	92683
Long Beach Memorial Medical Center	2801 Atlantic Ave	Long Beach	CA	90806
Long Beach Memorial Medical Ctr Miller Children's	2801 Atlantic Ave	Long Beach	CA	90806
Orange Coast Memorial Medical Center	9920 Talbert Ave	Fountain Valley	CA	92708
Orange County Global Medical Center	1001 N Tustin Ave	Santa Ana	CA	92705
Placentia Linda Hospital	1301 Rose Dr	Placentia	CA	92870
Prime HealthCare La Palma Intercommunity Hosp	7901 Walker St	La Palma	CA	90623
Providence Mission Hospital	27700 Medical Center Rd	Mission Viejo	CA	92691
Providence Mission Hospital	31872 Coast Hwy	Laguna Beach	CA	92651
Providence Mission Hospital Regional Medical Ctr	27700 Medical Center Rd	Mission Viejo	CA	92691
Providence St. Joseph Hospital	1100 W Stewart Dr	Orange	CA	92868
Providence St. Joseph Hospital Orange	1100 W Stewart Dr	Orange	CA	92868
Providence St. Jude Medical Center	101 E Valencia Mesa Dr	Fullerton	CA	92835
Providence St. Jude Medical Center - Rehab Unit	101 E Valencia Mesa Dr	Fullerton	CA	92835
Saddleback Memorial Medical Center	24451 Health Center Dr	Laguna Hills	CA	92653
South Coast Global Medical Center	2701 S Bristol St	Santa Ana	CA	92704
UCI Medical Center	101 The City Dr South	Orange	CA	92868
West Anaheim Medical Center	3033 W Orange Ave	Anaheim	CA	92804
Whittier Hospital Medical Center	9080 Colima Rd	Whittier	CA	90605

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AMENDMENT I TO
HOSPITAL SERVICES CONTRACT

THIS AMENDMENT I TO THE HOSPITAL SERVICES CONTRACT ("Amendment I") is effective as of July 1, 2021, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and _____("Hospital"), with respect to the following facts:

RECITALS

A. CalOptima and Hospital have entered into a Hospital Services Contract ("Contract"), by which Hospital has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Hospital desire to amend this Contract to revise compensation and CalOptima programs, including Medicare Advantage (OneCare) which is being added to this Contract and will supersede any and all prior contracts for OneCare.

NOW, THEREFORE, the parties agree as follows:

1. Attachment A, "Hospital Services", shall be deleted in its entirety and replaced with the attached Attachment A – Amendment I, "Hospital Services".

2. Attachment B, "Compensation", shall be deleted in its entirety and replaced with the attached Attachment B – Amendment I, "Compensation".

3. Attachment B-1, "Medi-Cal Compensation Rates for Adult Expansion Members", shall be deleted in its entirety and replaced with the attached Attachment B-1 – Amendment I, "Medi-Cal Compensation Rates for Adult Expansion Members".

4. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and Hospital have executed this Amendment.

FOR HOSPITAL:	FOR CALOPTIMA:
_____	_____
Signature	Signature
_____	Ladan Khamseh
Print Name	Print Name
_____	Chief Operation Officer
Title	Title
_____	_____
Date	Date

ATTACHMENT A – AMENDMENT I

HOSPITAL SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 CalOptima Programs. Hospital shall furnish covered services to eligible members in the following CalOptima Programs:

___X__	Medi-Cal Program
___X__	OneCare Program
___X__	Cal MediConnect Program/OneCare Connect
___X___	PACE Program

ARTICLE 2
HOSPITAL SERVICES

2.1. Hospital is responsible for providing all covered Hospital Services, as authorized by CalOptima or designee, provided that such services are available at Hospital, within Hospital's capacity and capability to provide, and Medically Necessary, including but not limited to:

1. Inpatient hospitalization for medical or surgical treatment in a ward or semi-private accommodation, unless a private room is Medically Necessary;
2. Hospitalization in an intensive care unit or special care unit;
3. Pediatric services;
4. Maternity services;
5. Psychiatric and substance abuse services;
6. Newborn nursery, all levels;
7. Ancillary services and supplies, including laboratory and radiology services;
8. Administration of outpatient prescription drugs (take home medications) in instances where continuation of hospital-based treatment shall not be interrupted: three (3) day supply minimum;
9. Emergency Department Services (as provided in Section 2.3 of this Contract, Emergency Services do not require prior authorization);
10. Outpatient services at Hospital's surgicenter or similar freestanding facility, or in Hospital's outpatient department(s); and
11. Administration of blood, blood plasma, or its derivatives, including cost of blood, blood plasma, or its derivatives.

ATTACHMENT B – AMENDMENT I

COMPENSATION

For Covered Services provided to CalOptima Medi-Cal Members under this Contract, CalOptima shall reimburse Hospital, and Hospital shall accept as payment in full from CalOptima the lesser of billed charges or the following amounts:

I. Medi-Cal
(For Medi-Cal Expansion Members please see Attachment B-1)

Inpatient Services

All inpatient facility services shall be paid at XX% of Hospital's then-current California Medi-Cal program APR-DRG rate. Inpatient services include emergency department services when a member is admitted within twenty-four (24) hours of an emergency department visit. Inpatient rates are all inclusive. CalOptima Policy FF.1005c: Special Payments: High Cost Exclusion Items shall not apply to any inpatient services under this Contract.

Inpatient admissions to the hospital prior to the effective date of any rate amendment and where the Member is still inpatient on the date of this amendment, shall be paid at the rates in place at the time of admission for the entire length of the stay.

Acute administrative days shall be paid at 100% of the Medi-Cal reimbursement and per CalOptima's policy regarding the criteria for authorizing acute administrative days.
Billing and reimbursement will be in accordance with Medi-Cal payment guidelines.

Outpatient Services

- Outpatient services (excluding drugs) shall be reimbursed at XX% of Medi-Cal reimbursement rates.
- Outpatient administered drugs shall be reimbursed at XX% of Medi-Cal reimbursement rates.
- Outpatient services not contained in the Medi-Cal fee schedule at the time of services are not reimbursable.

Billing and reimbursement will be in accordance with Medi-Cal payment guidelines.

II. Medicare Advantage (OneCare)

I.	INPATIENT ACUTE CARE	XX% of Medicare Allowable Rates
II.	OUTPATIENT CARE	XX% of Medicare Allowable Rates

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Footnotes:

1. For Medicare Part A or Part B services provided to CalOptima Medicare Advantage Enrollee Patients, Hospital's compensation shall equal the applicable rate shown on this Attachment B.

2. Billing and reimbursement will be in accordance with Medicare payment guidelines.

3. All physician fees are excluded.

4. In the event of a contracted rate change, the rate in place at the time of admission is the rate that shall be paid.

III. Cal MediConnect (OneCare Connect)

I.	INPATIENT ACUTE CARE	XX% of Medicare Allowable Rates
II.	OUTPATIENT CARE	XX% of Medicare Allowable Rates

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Footnotes:

1. For Medicare Part A or Part B services provided to CalOptima Medicare Advantage Enrollee Patients, Hospital's compensation shall equal the applicable rate shown on this Attachment B.

2. Billing and reimbursement will be in accordance with Medicare payment guidelines.

3. All physician fees are excluded.

4. In the event of a contracted rate change, the rate in place at the time of admission is the rate that shall be paid.

IV. PACE

I.	INPATIENT ACUTE CARE	XX% of Medicare Allowable Rates
II.	OUTPATIENT CARE	XX% of Medicare Allowable Rates

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Footnotes:

1. For Medicare Part A or Part B services provided to CalOptima Medicare Advantage Enrollee Patients, Hospital's compensation shall equal the applicable rate shown on this Attachment B.

2. Billing and reimbursement will be in accordance with Medicare payment guidelines.

3. All physician fees are excluded.

4. In the event of a contracted rate change, the rate in place at the time of admission is the rate that shall be paid.

ATTACHMENT B-1

MEDI-CAL COMPENSATION RATES FOR ADULT EXPANSION MEMBERS

Compensation rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future payments to CalOptima, CalOptima will amend the Contract to adjust payments made to the Hospital.

For Covered Services provided to CalOptima Medi-Cal Adult Expansion Members under this Contract, CalOptima shall reimburse Hospital, and Hospital shall accept as payment in full from CalOptima the lesser of billed charges or the following amounts:

I. Medi-Cal

Inpatient Services

All inpatient facility services shall be paid at XX% of Hospital's then-current California Medi-Cal program APR-DRG rate. Inpatient services include emergency department services when a member is admitted within twenty-four (24) hours of an emergency department visit. Inpatient rates are all inclusive. CalOptima Policy FF.1005c: Special Payments: High Cost Exclusion Items shall not apply to any inpatient services under this Contract.

Inpatient admissions to the hospital prior to the effective date of any rate amendment and where the Member is still inpatient on the date of this amendment, shall be paid at the rates in place at the time of admission for the entire length of the stay.

Acute administrative days shall be paid at 100% of the Medi-Cal reimbursement and per CalOptima's policy regarding the criteria for authorizing acute administrative days.
Billing and reimbursement will be in accordance with Medi-Cal payment guidelines.

Outpatient Services

- Outpatient services (excluding drugs) shall be reimbursed at XX% of Medi-Cal reimbursement rates.
- Outpatient administered drugs shall be reimbursed at XX% of Medi-Cal reimbursement rates.
- Outpatient services not contained in the Medi-Cal fee schedule at the time of services are not reimbursable.

Billing and reimbursement will be in accordance with Medi-Cal payment guidelines.

AMENDED AND RESTATED

HOSPITAL SERVICES CONTRACT

This Hospital Services Contract (the "Contract") is entered into by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and _____ ("Hospital"), a California Corporation, with respect to the following:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State of California, Department of Health Care Services ("DHCS") ("DHCS Contract"), pursuant to which it is obligated to arrange and pay for the provision of health care services to certain Medi-Cal eligible beneficiaries in Orange County (referred to herein as the "Medi-Cal Program").

C. CalOptima has entered into a contract with the Department of Health and Human Services ("HHS"), Centers for Medicare and Medicaid Services ("CMS"), to operate a Medicare Advantage ("MA") plan pursuant to Title II of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-73) ("MMA"), and to offer Medicare covered items and services to eligible individuals (referred to herein as the "OneCare Program"). CalOptima, as a dual-eligible Special Needs Plan (dual SNP), may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and the California Department of Health Care Services (DHCS).

D. CalOptima has entered into a participation contract with the State of California, acting by and through the Department of Health Care Services ("DHCS" or "State"), and the Department of Health and Human Services ("HHS"), acting by and through the Centers for Medicare & Medicaid Services ("CMS"), to furnish health care services to Medicare/Medi-Cal enrollees who are enrolled in CalOptima's Cal MediConnect program ("DHCS/CMS Cal MediConnect Contract"). This program will begin operation, subject to final approval of DHCS and CMS, no sooner than July 1, 2015.

E. CalOptima desires to provide services and Hospital is willing to provide services to dually eligible Medi-Cal and Medicare Enrollees to receive full benefits under Medicare and Medi-Cal.

F. Hospital is a provider of the items and services described in this Contract and has all certifications, licenses and permits necessary to furnish such items and services.

G. CalOptima desires to engage Hospital to furnish, and Hospital desires to furnish, certain items and services to CalOptima Members as described herein. CalOptima and Hospital desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
DEFINITIONS

The following definitions, and any additional definitions set forth in attachments and schedules attached hereto, apply to the terms set forth in this contract:

1.1. “Accreditation organization” means any organization including without limitation, the national committee for quality assurance (**NCQA**), joint commission on accreditation of healthcare organizations (**JCAHO**) and/or other entities engaged in accrediting, certifying and/or approving CalOptima, hospital and/or their respective programs, centers or services**.**

1.2. "adult expansion member” means a member enrolled in aid codes designated by the State, including L1 and M1, as newly eligible who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y).

1.3. “Advance Directive” means a written instruction (such as that required under the Federal Patient Self-Determination Act, 42 U.S.C. Sections 1395cc(f) and 1396a(w), and implementing regulations, the California Health Care Decisions Law, Probate Code Sections 4600 *et seq*., or durable power of attorney for health care), relating to the provision of medical care when an individual is incapacitated.

1.4. "Cal MediConnect" means a CalOptima Program which furnishes health care services to Medicare/Medi-Cal members who are enrolled in CalOptima's Cal MediConnect Program. Cal MediConnect is also referred to as OneCare Connect.

1.5. “California Children’s Services (CCS)” means those services authorized by the CCS Services Program for the diagnosis and treatment of the CCS Eligible Conditions of a specific Member.

1.6. “California Children’s Services (CCS) Eligible Condition(s)”, means a physically handicapping condition defined in Title 22 CCR Sections 41515.2 through 41518.9.

1.7. “California Children’s Services (CCS) Program” means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS Eligible Conditions.

1.8. “CalOptima Direct” or “COD” means a program CalOptima administers for CalOptima beneficiaries not enrolled in a Health Network.

1.9. “CalOptima Policies” means CalOptima policies and procedures relevant to this Contract, as amended from time to time at the sole discretion of CalOptima.

1.10. “CalOptima Programs” means the Medi-Cal, OneCare, Program of All-Inclusive Care for the Elderly (PACE) and Cal MediConnect (OneCare Connect) programs administered by CalOptima. Hospital participates in the specific CalOptima Program(s) identified on Attachment A.

1.11. "CalOptima's Regulators" means those government agencies that regulate and oversee CalOptima's and its FDR’s activities and obligations under this Contract including, without limitation, the Department of Health and Human Services Inspector General, the Centers for Medicare and Medicaid Services, the California Department of Health Care Services, and the California Department of Managed Health Care, the Comptroller General, the Department of Health and Human Services and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract.

1.12. “CCS Provider” or “CCS-Paneled Provider(s)” means any of the following providers when used to treat Members for a CCS Eligible Condition:

(a) A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106.

(b) A licensed acute care hospital approved by the CCS Program.

(c) A special care center approved by the CCS Program.

1.13. “Claim” means a request for payment submitted by Hospital in accordance with this Contract and CalOptima Policies.

1.14. “Clean Claim” means a Claim that has no defects or improprieties, contains all required supporting documentation, passes all system edits, and does not require any additional reviews by medical staff to determine appropriateness of services provided as further defined in the applicable CalOptima Program(s).

1.15. “Compliance Program” means the program (including, without limitation, the compliance plan, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima’s operations and practices and the practices of the members of its Board of Directors, employees, contractors and Hospitals comply with applicable law and ethical standards.

1.16. "Coordination of Benefits" or "COB" refers to the determination of order of financial responsibility which applies when two or more health benefit plans provide coverage of items and services for an individual.

1.17. “Covered Services” means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision

1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the State Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and, effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Covered Services shall include CCS Services (as defined in Subdivision 7 of Division 2 of Title 22 of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

1.18. "Downstream Entity" means all persons or entities with which Hospital has entered into a written subcontract (acceptable to CMS) to perform administrative functions and/or health care services to satisfy Hospital's obligations to CalOptima under this Contract, continuing down to the ultimate provider of services. The term "Hospital" as used in the terms of this Contract shall also include its subcontractors when such subcontractors are Downstream Entities as defined herein even if not expressly referenced in the particular provision.

1.19. "Effective Date" means the effective date of commencement of the Contract as provided in Article 10.

1.20. "Emergency Medical Condition" means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or

2. serious impairment to bodily functions; or

3. serious dysfunction of any bodily organ or part.

1.21. "Emergency Services" means those health care services (including inpatient and outpatient) that are Covered Services and for which Hospital and Hospital Providers are duly licensed and qualified to furnish that are needed to evaluate or stabilize an Emergency Medical Condition.

1.22. "Encounter Data" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators."

1.23. “Enrollee” means a Medi-Cal/Medicare eligible individual who is enrolled in the CalOptima Cal MediConnect Program, or OneCare Program and may also be referred to as Member.

1.24. “Family Planning” means Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1) medical and surgical services performed by and under the direct supervision of a licensed physician for the purposes of Family Planning; 2) laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or associated with Family Planning procedures; 3) patient visits for the purpose of Family Planning; 4) Family Planning counseling services provided during a regular patient visit; 5) tubal ligations; 6) vasectomies; 7) contraceptive drugs or devices; and, 8) treatment for complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.

1.25. “First Tier, Downstream and Related Entity” or “FDR” means a party that enters into a written agreement (acceptable to CMS and DHCS) to provide administrative or health care services to CalOptima under the DHCS/CMS Cal MediConnect Contract.

1.26. “Government Agencies” means Federal and State agencies that are parties to the Government Contracts, including HHS/CMS, DHCS, DMHC and MRMIB and their respective agents and contractors, including quality improvement organizations (QIOs).

1.27. “Government Contract(s)” means the written contract(s) between CalOptima and the Federal and/or State government pursuant to which CalOptima administers and pays for covered items and services under a CalOptima Program.

1.28. “Government Guidance” means Federal and State operational and other instructions related to the coverage, payment and/or administration of CalOptima Programs.

1.29. “Health Network” means a physician group, physician-hospital consortium or health care service plan, such as an HMO, which is contracted with CalOptima to provide items and services to Members.

1.30. “Hospital Services” means those Medically Necessary inpatient and outpatient services, including medical services and supplies that are Covered Services and that Hospital will provide to Members as identified in Attachment A.

1.31. “Licenses” means all licenses and permits that Hospital is required to have in order to participate in the CalOptima Programs and/or furnish the items and/or services described under this Contract.

1.32. “Long Term Care Facility” means a facility that is licensed to provide skilled nursing facility services, intermediate care facility services or sub-acute care services.

1.33. “Low Income Health Program” or “LIHP” Member means an Adult Expansion Member who was formerly a LIHP enrollee and transitioned to Medi-Cal under aid code L1.

1.34. “Medi-Cal” is the name of the Medicaid program for the State of California (*i.e.*, the program authorized by Title XIX of the Federal Social Security Act and the regulations promulgated thereunder).

1.35. “Medical Necessity” or “Medically Necessary” means reasonable and necessary services to protect life, prevent illness or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22, CCR Section 51303(a) and 42 CFR 438.210(a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132(v).

1.36. “Medical Record” means any record kept or required to be kept by any Provider that documents all of the medical services received by the Member, including, without limitation, inpatient, outpatient, emergency care, and Referral requests and authorizations, as required to be kept pursuant to applicable State and Federal laws.

1.37. “Medicare” means the Federal health insurance program defined in Title XVIII of the Federal Social Security Act and regulations promulgated thereunder.

1.38. “Medicare Secondary Payer” or “MSP” means the Medicare coordination of benefits (COB) requirements as incorporated in MA regulations.

1.39. “Member” means any person who has been determined to be eligible to receive benefits from, and is enrolled in, one or more CalOptima Program.

1.40. “Memorandum/Memoranda of Understanding” or “MOU” means an agreement(s) between CalOptima and an external agency(ies), which delineates responsibilities for coordinating care to CalOptima Members.

1.41. “Minimum Provider Standards” means the minimum participation criteria established by CalOptima for specified Providers that must be satisfied in order for a Provider to submit claims and/or receive reimbursement from the CalOptima program for items and/or services furnished to CalOptima members as identified in CalOptima Policies.

1.42. “Non-Covered Services” means those items and services that are not covered benefits under a particular CalOptima Program in accordance with the Evidence of Coverage or Member handbook and applicable State and Federal laws and regulations.

1.43. “Non-Participating Provider” means an institutional, professional or other Provider of health care services who has not entered into a written agreement with CalOptima, either directly or through another organization, to provide Covered Services to Members.

1.44. “Participating Provider” means an institutional, professional or other Provider of health care services who has entered into a written agreement with CalOptima to provide Covered Services to Members.

1.45. “Participation Status” means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or felony conviction (if applicable) as specified in CalOptima's Compliance Program and CalOptima Policies.

1.46. “Physician” means a person with an unrestricted license to practice medicine or osteopathy in the state in which they practice.

1.47. “Preclusion List” means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries

1.48. “Post-stabilization Services” means Covered Services that are provided after a Member is stabilized following an Emergency Medical Condition in order to maintain the stabilized condition or, under circumstances described in 42 CFR 438.114(e) to improve or resolve the Member’s condition.

1.49. “Prior Authorization” means the process by which CalOptima approves, usually in advance of the rendering, requested medical and other services pursuant to the utilization management program for the CalOptima Programs.

1.50. “Program of All-Inclusive Care for the Elderly” or “PACE” means a program that features a comprehensive medical and social services delivery system using an Interdisciplinary Team (IDT) approach in an adult day health center that is supplemented by in-home and referral services, in accordance with the enrollee’s needs. The IDT is the group of individuals to which a PACE participant is assigned who are knowledgeable clinical and non-clinical PACE center staff responsible for the holistic needs of the PACE participant and who work in an interactive and collaborative manner to manage the delivery, quality, and continuity of participants’ care. All PACE program requirements and services will be managed directly through CalOptima.

1.51. “Provider” means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution that furnishes health care items or services.

1.52. “Provider Manual” means that document, as amended from time to time, that is prepared by CalOptima and describes CalOptima’s Policies as they affect Providers.

1.53. “QMI Program” means CalOptima Quality Management and Improvement Program.

1.54. “Referral” means the process by which a Physician directs a Member to seek and obtain Covered Services from a health professional or for care at a facility.

1.55. "Stabilize" or "Stabilized" means with respect to an Emergency Medical Condition, to provide such medical treatment of the condition, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, the woman has delivered the child and the placenta.

1.56. "Subcontract" means a contract entered into by Hospital with a party that agrees to furnish items and/or services to CalOptima Members, or administrative functions or services related to Hospital fulfilling its obligation to CalOptima under the terms of this Contract if, and to the extent, permitted under this Contract.

1.57. "Subcontractor" means a Provider or any organization or person who has entered into Subcontract with Hospital for the purposes of providing or facilitating the provision of items and/or services under this Contract.

1.58. "Threshold Languages/Concentration Languages" means those languages as determined by State requirements per MMCD Policy Letter 99-03, or any update or revision thereof.

1.59. "Urgent Care" means services that are not Emergency Services and are generally services to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury for which treatment cannot be delayed as specifically defined by the rules and regulations governing the applicable CalOptima Program.

1.60. "Urgently Needed Services" means medically necessary Hospital Services that are not Emergency Services, provided generally when the Member is temporarily absent from the CalOptima service area as described in this Contract, and which are immediately required as a result of an unforeseen illness, injury or condition and for which it was not reasonable, given the circumstances, to obtain the services through the Member's Health Network.

1.61. "UM Program" means CalOptima's Utilization Management Program.

1.62. "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

ARTICLE 2
FUNCTIONS AND DUTIES OF HOSPITAL

2.1. Provision of Hospital Services.

2.1.1. Hospital shall furnish Hospital Services identified in Attachment A to eligible Members in accordance with the terms of this Contract and CalOptima Policies.

Hospital agrees that, to the extent feasible and within available capacity and capability, Hospital Services provided by it will be made available and accessible

to Members promptly and in a manner that ensures continuity of care and compliance with Section 2.6 of this Contract.

2.1.2. Throughout the term of this Contract, and subject to the conditions of the Contract, Hospital shall maintain the quality of its services and personnel in accordance with the requirements of this Contract, to meet Hospital's obligation to provide Hospital Services hereunder.

2.1.3. In accordance with Section 2.34 of this Contract, Hospital and its Subcontractors shall furnish Hospital Services to Members under this Contract in the same manner as those services are provided to other patients and may not impose any limitations on the acceptance of Members for care or treatment that are not imposed on other patients.

2.2. Hospital Providers. Upon request, Hospital shall provide CalOptima with a list of Hospital medical staff members, together with any information requested by CalOptima for the administration of its QMI Program, unless such information is protected under California Evidence Code Section 1157 or other privilege statute. If a member of Hospital's medical staff is debarred from participation in a state or federal health care program and/or has his/her license to practice medicine suspended or revoked, Hospital shall recommend that the Hospital medical staff immediately prevent the physician from providing any professional services to Members. Hospital shall immediately notify CalOptima of any physician who has been debarred from participating in a state or federal health care program, or whose license to practice medicine has been suspended or revoked.

2.3. Emergency Services. Hospital shall comply with all applicable State and Federal laws and regulations governing the provision and payment of Emergency Services including, without limitation, the following requirements:

2.3.1. Hospital shall furnish Emergency Services on a twenty-four (24) hours per day, seven (7) days a week basis. CalOptima shall reimburse Hospital for Emergency Services without Prior Authorization.

2.3.2. Payment will not be denied to Hospital where the Member had an Emergency Medical Condition but the absence of immediate medical attention would not have resulted in an outcome as defined in Section 1.17 above or where CalOptima or one of its Participating Providers instructs the Member to seek Emergency Services.

2.3.3. An Emergency Medical Condition shall not be limited based on a list of diagnoses or symptoms.

2.3.4. The attending emergency Physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge.

2.4. Notification of Emergency Services. Hospital agrees to notify CalOptima within twenty-four (24) hours of a CalOptima Member's Initial Emergency Encounter which means the Member's presentation to the emergency department for outpatient Emergency Services or the Member's inpatient emergency admission, whichever occurs first. If the Initial Emergency Encounter is on a holiday or weekend, notification to the Member's Health Network shall be made the following business day, or the time Member identity is known, or would have been known with the exercise of reasonable diligence. Hospital agrees that CalOptima's UM staff shall have access to timely information and documentation in order to enable CalOptima to review emergency admissions in order to certify the number of inpatient days authorized under the UM Program. Emergency Services provided within twenty-four (24) hours of an inpatient admission will be included in the inpatient per diems and/or case rates.

2.5. Members with Disabilities. Hospital will accommodate inpatient and outpatient surgical and medical procedures for members with disabilities**,** including but not limited to dental procedures under general anesthesia, to the extent that Hospital can provide such services.

2.6. UM Program. Hospital shall comply with CalOptima's UM Program including:

2.6.1. Hospital acknowledges and agrees that CalOptima has implemented and maintains a UM Program that addresses evaluations of Medical Necessity and processes to review and approve the provision of items and services, including Hospital Services, to Members. Hospital shall comply with the requirements of the UM Program including, without limitation, those criteria applicable to the Hospital Services as described in this Contract.

2.6.2. Hospital shall comply with all Prior Authorization, concurrent and retrospective review and authorization requirements as set forth in CalOptima Policies. Prior Authorization is not required for Emergency Services.

2.6.3. Hospital agrees to allow CalOptima staff to initiate visits with Hospital staff immediately upon admission of any Member to evaluate the appropriateness of the admission and continued stay.

2.6.4. Except for Emergency Services, Hospital agrees to admit members to Hospital only upon presentation to Hospital of the proper Referral form or authorization information designated by CalOptima (and/or a Health Network) certifying the Hospital Services and the number of inpatient days authorized under the UM Program. Hospital shall provide non-emergency Hospital Services to Members during the term of this Contract only upon CalOptima's prior authorization unless prior authorization is not required for a particular item or service under the CalOptima Program. Failure to secure prior authorization from the CalOptima Utilization Management Department may result in denial of claims submitted to CalOptima. In the event a Referral is not presented, Hospital may admit a Member if it verifies, prior to admission, that the admission is approved by CalOptima and in accordance with the policies and procedures of CalOptima's

UM Program. Hospital shall obtain a tracking number from CalOptima at the time of admission, which Hospital shall indicate on all UB-92 Forms submitted to CalOptima for payment. In the event Hospital does not request a CalOptima authorization and Hospital does not receive CalOptima's authorization prior to admission, CalOptima shall not pay Hospital for such admission.

2.6.5. Hospital agrees to obtain authorization for all admissions by notifying CalOptima within 24 hours or the next business day from time of the admission or time Member identity is known, or would have been known with the exercise of reasonable diligence. Hospital also agrees to request authorization for all admissions to Long Term Care Facilities. Furthermore, Hospital agrees to cooperate with CalOptima in the functions of discharge planning and transferring Members to participating providers as is appropriate for all levels of care required by the Member and in accordance with CalOptima Policies. Hospital's failure to obtain pre-authorizations and /or provide timely concurrent reviews may result in a reduction in payment in accordance with CalOptima policies.

2.6.6. Hospital shall permit CalOptima's UM Department staff and other qualified representatives of CalOptima to conduct on site concurrent reviews of the medical records of Members. CalOptima staff shall notify Hospital's utilization management department prior to conducting such on site reviews, shall wear appropriate identification, and shall schedule at times reasonable for Hospital.

2.7. Transfer of Care. Upon request by a CalOptima Member, Hospital shall assist the CalOptima Member in the orderly transfer of such CalOptima Member's medical care. In doing so, Hospital shall make available to the new Provider of care for the Member, copies of the Medical Records, patient files, and other pertinent information necessary for efficient medical case management of Member. In no circumstance shall a CalOptima Member be billed for this service.

2.8. CCS Eligible Services. If Hospital is not a CCS paneled hospital authorized by CCS to provide the specific CCS-eligible Services required by Members, Hospital agrees to cooperate with CalOptima in the transfer of Members with CCS eligible conditions to an appropriately authorized CCS paneled Hospital.

2.9. Eligibility. Hospital shall verify a Member's eligibility for the applicable CalOptima Program benefits upon receiving a request for Covered Services, and at the beginning of each calendar month thereafter during the continued provision of such services.

2.10. Medi-Cal Member Retroactive Eligibility. For Hospital Services provided to Members whose eligibility in Medi-Cal has been determined retroactively, Hospital agrees to the following:

2.10.1. To verify eligibility of Medi-Cal Members through the State of California's Beneficiary Eligibility Verification system and to report such eligible Members to CalOptima within forty-eight (48) hours of the Hospital becoming aware of Member's eligibility and enrollment in CalOptima.

2.10.2. Except for Emergency Services, Hospital's failure to notify CalOptima within forty-eight (48) hours of becoming aware of a Medi-Cal Member's eligibility may result in non-payment for services rendered.

2.10.3. The admission and length of stay of the Member shall be subject to retrospective review for Medical Necessity.

2.10.4. To submit complete Medical Records with all submitted claims.

2.11. Changes in Capacity. Hospital shall provide at least ninety (90) days' prior written notice to CalOptima of any significant changes in the capacity of Hospital or its Hospital Providers to furnish Hospital Services to Members. Hospital shall use reasonable efforts to eliminate or remedy any condition that results in a significant adverse change in capacity including (i) Hospital's inability to properly serve Members due to a lack of beds or other services or (ii) closure of any facility or service unit used by Hospital or its Providers.

2.12. Licensure/Certification of Employees. Each of Hospital's employees furnishing services under this Contract shall maintain in good standing at all times during this Contract, the necessary licenses or certifications required by State and Federal law or any Accreditation Organization to provide or arrange for the provision of Covered Services to Members.

2.13. Licensure. Hospital shall be and remain during the period of this Contract duly licensed by the State of California as a general acute care hospital. Hospital is currently in good standing, and at all times during the term of this Contract shall maintain good standing with the following:

2.13.1. all licenses, certificates and/or approvals required under State and Federal Law for the performance of Covered Services required by this Contract; and

2.13.2. certification under Medicaid and Medicare; and

2.13.3. accreditation by the Joint Commission on Accreditation of Healthcare Organizations.

2.14. Regulatory Approvals. Hospital represents and attests that it has, and shall maintain during the term of this Contract, applicable enrollment in the Medi-Cal and Medicare Programs and maintains National Provider Identifiers (NPIs).

2.15. Good Standing. Hospital represents it is in good standing with State licensing boards (applicable to its business), DHCS, CMS and the HHS Officer of Inspector General ("OIG").

2.16. Notices and Citations. Hospital shall notify CalOptima in writing of any report or other writing of any State or Federal agency and/or Accreditation Organization that regulates Hospital that contains a citation, sanction and/or disapproval of Hospital's failure to meet

any material requirement of State or Federal law or any material standards of an Accreditation Organization.

2.17. Professional Standards. All Hospital Services provided or arranged for under this Contract shall be provided or arranged by duly licensed, certified or otherwise authorized professional personnel in manner that (i) meets the cultural and linguistic requirements of this Contract; (ii) within professionally recognized standards of practice at the time of treatment; (iii) in accordance with the provisions of CalOptima's UM and QMI Programs; and (iv) in accordance with the requirements of State and Federal law and all requirements of this Contract.

2.18. Marketing Requirements. Hospital shall comply with CalOptima's marketing guidelines relevant to the pertinent CalOptima Program(s) and applicable laws and regulations.

2.19. Identification of Hospital. Hospital agrees that CalOptima may list the name, address, and telephone number of Hospital and a description of Hospital's facilities and services in CalOptima's roster of Participating Providers, which is given to Members and/or prospective Members. However, CalOptima is not obligated to list the name of any particular Provider in the roster. Hospital and CalOptima agree that the use of the other party's trademarks or logos is prohibited without prior written approval of that party. Except as provided in this paragraph, CalOptima may not use Hospital's name for marketing or advertising purposes without prior written permission from Hospital.

2.20. Disclosure of Hospital Ownership. Hospital shall provide CalOptima with the following information, as applicable: (a) names of all officers of Hospital's governing board; (b) names of all owners of Hospital; (c) names of stockholders owning more than five percent (5%) of the stock issued by Hospital; and (d) names of major creditors holding more than five percent (5%) of the debt of Hospital. Hospital shall complete any disclosure forms required under the CalOptima Programs as requested by CalOptima. Hospital shall notify CalOptima immediately of any changes to the information included by Hospital in the disclosure forms submitted to CalOptima.

2.21. Clinical Laboratory Improvement Amendments. Hospital shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

2.22. Admissions to Long Term Care Facility. Hospital shall plan the admission of Members to Long Term Care Facilities, as determined by CalOptima Policies. Hospital shall prospectively notify CalOptima of possible admissions to Long-Term Care Facilities and comply with the planning process for the assessment of Members identified as needing long-term care as determined by CalOptima Policies. For Members assessed as appropriate for long long-term care, Hospital shall assist CalOptima as required to place Members in Long-Term Care Facilities contracted with CalOptima.

2.23. Newborn Services. For services provided to a child of a Member during the month of birth or the following month, Hospital shall bill for such services in accordance with the claim form completion instructions in the appropriate Medi-Cal Provider Manual relative to newborns.

2.24. Advance Directives. Hospital shall maintain written policies and procedures related to Advanced Directives in compliance with State and other applicable law. Hospital shall document patient records with respect to the existence of an Advance Directive in accordance with applicable law. Hospital shall not discriminate against any Member on the basis of that Member's Advance Directive status.

2.25. CalOptima QMI Program. Hospital acknowledges and agrees that CalOptima is accountable for the quality of care furnished to its Members in all settings including services furnished by Hospital. Hospital agrees, when reasonable and within capability of Hospital, that it is subject to the requirements of CalOptima's QMI Program and that it shall participate and cooperate in QMI Program activities as required by CalOptima. Such activities may include, but are not limited to, the provision of requested data and the participation in assessment and performance audits and projects (including those required by CalOptima's regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members. Hospital shall participate in CalOptima's QMI Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for CalOptima Members. Hospital shall cooperate with CalOptima and Government Agencies in any complaint, appeal or other review of Hospital Services (*e.g.*, medical necessity) and shall accept as final all decisions regarding disputes over Hospital Services by CalOptima or such Government Agencies, as applicable, and as required under the applicable CalOptima Program.

2.26. Hospital Quality Improvement Program. Hospital shall establish, maintain and operate a quality improvement program, which shall include an annual quality improvement work plan and an annual performance evaluation of such work plan, which is consistent with current industry standards, Quality Improvement System for Managed Care (QISMC), NCQA, Leapfrog, and/or JCAHO.

Hospital shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities and public reporting to consumers, as identified in CalOptima policy GG.1638.

2.27. CalOptima Oversight. Hospital understands and agrees that CalOptima is responsible for the monitoring and oversight of all duties of Hospital under this Contract, and that CalOptima has the authority and responsibility to: (i) implement, maintain and enforce CalOptima Policies governing Hospital's duties under this Contract and/or governing CalOptima's oversight role; (ii) conduct audits, inspections and/or investigations in order to oversee Hospital's performance of duties described in this Contract; (iii) require Hospital to take corrective action if CalOptima or a Government Agency determines that corrective action is needed with regard to any duty under this Contract; and/or (iv) revoke the delegation of any duty, if Hospital fails to meet CalOptima standards in the

performance of that duty. Hospital shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with the laws, accreditation agency standards, and/or CalOptima Policies governing the duties of Hospital or the oversight of those duties.

2.28. Linguistic and Cultural Sensitivity Services. Hospital shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. CalOptima will provide cultural competency, sensitivity, and diversity training. Hospital shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Hospital shall, in its policies, administration, and services, practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Hospital shall fully cooperate with CalOptima in the provision of cultural and linguistic services provided by CalOptima for Members receiving services from Hospital.

2.29. Provision of Interpreters. Hospital shall comply with Health and Safety Code Section 1259. To the extent that a CalOptima Member requires interpreter services beyond those mandated by that Health and Safety Codes Section, and to the extent that Hospital does not choose to provide such services, Hospital shall ensure that CalOptima is notified that the Member requires additional interpreter services, and CalOptima shall provide such services at its own expense. Interpreter services under this Section include both linguistic interpreter services and interpreter services for the deaf and hard of hearing, as may be necessary to ensure effective communication regarding treatment, diagnosis, and medical history or health education pursuant to the requirements contained in this Contract and CalOptima Policies. Interpreters shall be used where needed and when technical, medical, or treatment information is to be discussed. Hospital shall not require a Member to use friends or family as interpreters. However, a friend or family member may be used when the use of the family member or friend: (a) is requested by a Member; (b) will not compromise the effectiveness of service; (c) will not violate a Member's confidentiality; and (d) Member is advised that an interpreter is available through CalOptima at no cost to the Member. Hospital may utilize interpreter services provided through the Cultural and Linguistic Coordinator within CalOptima's customer service department, as appropriate, at no charge to Hospital.

2.30. CalOptima's Compliance Program and Other Guidance. Hospital and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("Hospital's Agents") shall comply with the requirements of CalOptima's Compliance Program, including CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Plan and Code of Conduct available to Hospital and Hospital shall make them available to Hospital's Agents. Hospital agrees to comply with, and be bound by, any and all MOUs, CalOptima financial bulletins and contract interpretation bulletins,

which provide changes, updates and clarifications regarding CalOptima financial policies and contract interpretations.

CalOptima intends to amend its Compliance Plan and Code of Conduct to allow for the substitution of provider compliance plans and codes of conduct for CalOptima's Compliance Plan and Code of Conduct. Provided that such substitution is approved by the Government Agencies, then, upon approval by CalOptima's Compliance Department, Hospital's Compliance Plan and Code of Conduct may be substituted for the CalOptima Compliance Plan and Code of Conduct under this Contract.

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

Hospital and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Hospital 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.

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

Hospital and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as

amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

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

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

Hospital and its Subcontractors will include the provisions of this Section in every Subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. Hospital and its Subcontractors will take such action with respect to any Subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event Hospital and its Subcontractors become involved in, or are threatened with litigation by a subcontractor or vendor as a result of such direction by DHCS, Hospital and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2.32. Compliance with Applicable Laws. Hospital shall observe and comply with all Federal and State laws and regulations, and requirements established in Federal and/or State programs in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects the Hospital's performance under this Contract. Hospital shall comply with applicable terms and conditions of the contracts between CalOptima and Government Agencies. In accordance with the California Public Records Act, CalOptima shall provide copies of its contracts with the Government Agencies upon request. Hospital understands and agrees that payments made by CalOptima are, in whole or in part, derived from Federal funds, and therefore Hospital is are subject to certain laws that are applicable to individuals and entities receiving Federal funds. Hospital agrees to comply with all applicable Federal laws, regulations, reporting requirements and CMS instructions, including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act.

2.33. No Discrimination/Harassment (Employees). During the performance of this Contract, Hospital shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religion, creed, color, national origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender, sexual orientation, or the use of family and medical care leave and pregnancy disability leave. Hospital shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Hospital shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder (Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Hospital shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

2.34. No Discrimination (Member). Hospital shall not discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary

discrimination); section 1557 of the Patient Protection and Affordable Care Act, and all rules and regulations promulgated pursuant thereto, and all other laws regarding privacy and confidentiality.

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (a) denying any Member any Covered Services or availability of a Provider, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services.

Hospital agrees to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Hospital shall take affirmative action to ensure that all Members are provided Covered Services without discrimination, except where medically necessary. For the purposes of this Section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

Hospital shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies.

2.35. Nondiscrimination—Member Visits. Hospital shall ensure that it permits a Member, at Member's choice, to be visited by the Member's domestic partner, the children of a Member's domestic partner, and the domestic partner of the Member's parent or children, in the same manner and to the same extent permitted for a Member's spouse or spouse's children, or the spouse of a Member's children or parents. Hospital shall include the language of this Section in any Subcontract for inpatient facility services.

2.36. Reporting Obligations. In addition to any other reporting obligations under this Contract, Hospital shall submit such reports and data relating to services covered under this Contract as are required by CalOptima, including, without limitations, to comply with requests from Government Agencies to CalOptima. CalOptima shall reimburse Hospital for reasonable costs for producing and delivering such reports and data.

2.37. Subcontract Requirements. If permitted by the terms of this Contract, Hospital may subcontract for certain functions covered by this Contract, subject t o the requirements of this Contract. Subcontracts shall not terminate the legal liability of Hospital under this Contract. Hospital must ensure that all Subcontracts are in writing and include any and

all provisions required by this Contract or applicable Government Programs to be incorporated into Subcontracts. Hospital shall make all Subcontracts available to CalOptima or its regulators upon request. Hospital is required to inform CalOptima of the name and business addresses of all Subcontractors. Hospital shall ensure that all Subcontractors providing services under this Contract to CalOptima Members comply with all applicable provisions of state and federal laws, regulations and program guidance when providing Covered Services to Members under this Contract. Additionally, Hospital shall require that all Subcontracts relating to the provision of Covered Services include, without limitation, the following provisions:

2.37.1. An agreement to make all books and records relative to the provision of and reimbursement for Covered Services furnished by Subcontractor to Hospital available at all reasonable times for inspection, examination or copying by CalOptima, Department of Health Care Services, Department of Health and Human Services and Department of Justice.

2.37.2. An agreement to maintain such books and records: (a) in accordance with the general standards applicable to such books and records and any record requirements in this Contract and CalOptima Policies; and (b) at the Subcontractor's place of business or at such other mutually agreeable location in California.

2.38. Hospital Agreement to Extend Terms and Rates. Hospital agrees to extend to CalOptima Health Networks the same terms regarding Hospital performance, duties and obligations and rates for Hospital Services provided to CalOptima Members enrolled in Health Networks as are set forth in this Contract.

2.39. Fraud and Abuse Reporting. To the extent required by and in compliance with CMS or other applicable federal and state laws, Hospital shall report to CalOptima all cases of suspected fraud and/or abuse related to rendering services provided under this contract to CalOptima members.

2.40. Participation Status. Hospital shall have Policies and Procedures to verify the Participation Status of Hospital's Practitioners. In addition, Hospital attests and agrees as follows:

2.40.1. Hospital and Hospital's Practitioners shall meet CalOptima's Participation Status requirements during the term of this Contract.

2.40.2. Hospital shall immediately disclose to CalOptima, including, but not limited to, any pending investigation involving, or any determination of, suspension, exclusion or debarment of Hospital or Hospital's Practitioners occurring and/or discovered during the term of this Contract.

2.40.3. Hospital shall take immediate action to remove any employee of Hospital that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to CalOptima

Members which may include but not limited to adverse decisions and licensure issues.

2.40.4. Hospital shall include the obligations of this Section in its Subcontracts.

2.40.5. CalOptima shall not make payment for a healthcare item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Hospital shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

2.41. Ethical and Religious Directives. Nothing in this Contract shall require Hospital to provide any services which would violate Hospital's Ethical and Religious Directives. Such services would include, but not be limited to, abortions not necessary to remedy a life-threatening condition of the mother, sterilizations not approved by Hospital guidelines, and euthanasia.

2.42. Tax Exempt Status. If Hospital is a tax-exempt entity, and at any time has a good faith reason to believe that this Agreement may jeopardize the tax-exempt status of Hospital, or any of its affiliates, under Section 501(c)(3) of the Internal Revenue Code and the ability of Hospital or any of its affiliates to obtain or maintain tax-exempt financing, the parties agree to amend this Agreement to the extent necessary to address such issues. Any such amendment shall attempt to preserve the parties' economic benefits of this Agreement to the greatest extent possible. In the event Hospital is advised by independent counsel in a written opinion that amendment of this Agreement will not be sufficient to address such issues, Hospital may terminate this Agreement as provided in Section 7.8 herein.

2.43. Physical Access for Members. Hospital shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

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

penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Hospital certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.

2.45. Member Rights. Hospital shall ensure that each Member's rights, as set forth in state and federal law as applicable to CalOptima's programs in this Contract, are fully respected and observed.

2.46. Whole Child Model Program Compliance. If Hospital is a CCS authorized facility, then in the provision of CCS services to CalOptima Members, the Hospital shall follow CCS Program guidelines, including CCS Program regulations, and where CCS clinical guidelines do not exist, Hospital will use evidence -based guidelines or treatment protocols that are medically appropriate to the Member's CCS Eligible Condition.

2.47. CCS Provider Compliance.

2.47.1. Only CCS-Paneled Providers may treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment.

2.47.2. If Hospital is a CCS-Paneled Provider, Hospital agrees to provide services for the Whole Child Model Program in accordance with this Contract and CalOptima Policies.

2.47.2.1. Effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Hospital shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

2.47.2.2. To ensure consistency in the provision of CCS Covered Services, Hospital shall use all current and applicable CCS Program guidelines, including CCS Program regulations. When applicable CCS clinical guidelines do not exist, Hospital shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Members' CCS Eligible Condition.

2.48. Government Claims Act. Hospital shall ensure that Hospital and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et seq.), including, but not limited to Government Code sections 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

2.49. Certification of Document and Data Submissions. All data, information, and documentation provided by Hospital to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR 438.604 and/or as otherwise required

by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Hospital's letterhead sign by the Hospital's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

2.50. Data Sharing Technology for Discharge Planning. Subject to compliance with all applicable laws and regulations, as well as all provisions of this Contract, Hospital agrees to evaluate and implement the use of data sharing technology for purposes set forth in California Health and Safety Code Section 1262.5, subdivisions (n)(4)(A) and (p), with respect to Members who are homeless patients, as defined in Health and Safety Code Section 1262.4.

ARTICLE 3

FUNCTIONS AND DUTIES OF CALOPTIMA

3.1. Payment. CalOptima shall pay Hospital for Hospital Services provided to CalOptima Members. Hospital agrees to accept the compensation set forth in Attachment B as payment in full from CalOptima for such Hospital Services. Upon submission of a Clean Claim, CalOptima shall pay Hospital pursuant to CalOptima Policies and Attachment B. Notwithstanding the foregoing, Hospital may also collect other amounts (e.g., copayments, deductibles, OHC and/or third party liability payments) where expressly authorized to do so under the CalOptima Program(s) and applicable law.

3.2. Service Authorization. CalOptima shall provide a written authorization process for Hospital Services pursuant to CalOptima Policies.

3.3. CalOptima Guidance. CalOptima shall make available to Hospital, all applicable Provider Manuals, financial bulletins and CalOptima Policies applicable to Hospital Services under this Contract.

3.4. Limitations of CalOptima's Payment Obligations. Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Hospital any amounts shall be subject to CalOptima's receipt of the funding from the Federal and/or State governments. CalOptima shall notify Hospital within two business days upon discovery of a payment issue related to this Section.

3.5. Identification Cards. CalOptima shall provide Members with identification cards indentifying Members as being enrolled in the applicable CalOptima program.

3.6. Care Management. CalOptima shall provide Care Management Services for Members through its Care Coordination Department.

3.7. Member Materials. CalOptima shall furnish Hospital any written materials that CalOptima wishes Hospital to provide to Members, including translations into threshold languages and at appropriate grade level, as appropriate.

ARTICLE 4
PAYMENT PROCEDURES

4.1. Billing and Claims Submission. Hospital shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

4.2. Prompt Payment. CalOptima shall make payments to Hospital in the time and manner set forth in CalOptima Policies related to the CalOptima Programs. Additional procedures related to claims processing and payment are set forth in the attached CalOptima Program Addenda.

4.3. Claim Completion and Accuracy. Hospital shall be responsible for the completion and accuracy of all Claims submitted whether on paper forms, tape or electronically including claims submitted for the Hospital by other parties. Use of a billing agent does not abrogate Hospital's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Hospital acknowledges that Hospital remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

4.4. Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Hospital notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.

4.5. COB. Hospital shall coordinate benefits with other programs or entitlements recognizing where other OHC is primary coverage in accordance with CalOptima Program requirements. Hospital acknowledges that Medi-Cal is the payor of last resort.

4.6. Member Financial Protections. Hospital and its Subcontractors shall comply with Member financial protections as follows:

4.6.1 Hospital agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Hospital for any amounts which are owed by, or are the obligation of, CalOptima. Hospital agrees that Enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the provider will (A) accept the plan payment as payment in full, or (B) bill the appropriate State source as required at 42 CFR §422.504(g)(1)(iii).

4.6.2 In no event, including but not limited to nonpayment by CalOptima, CalOptima's or the Hospital's insolvency, or breach of this Contract by CalOptima, shall the Hospital bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons acting on the behalf of a Member, or against the State of California, for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Hospital may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

4.6.3 This provision does not prohibit Hospital from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

4.6.4 Upon receiving notice of Hospital invoicing or balance billing a Member for the difference between the Hospital's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Hospital or take other action as provided in this Contract.

4.6.5 This Section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members.

4.7. Overpayments and CalOptima Right to Recover. Hospital has an obligation to report any overpayment identified by Hospital, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Hospital, or of receipt of notice of an overpayment identified by CalOptima. Hospital acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Hospital, CalOptima shall have the right to recover such amounts from Hospital by recoupment or offset from current or future amounts due from CalOptima to Hospital, after giving Hospital notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Hospital to CalOptima, including, but not limited to, amounts due because of:

4.7.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this Contract.

4.7.2 Payments made for services provided to a Member that is subsequently determined to have not been eligible on the date of service.

4.7.3 Unpaid Conlan reimbursements owed by Hospital to a Member.

4.7.4 Payments made for services provided by a Hospital that has entered into a private contract with a Medicare beneficiary for Covered Services.

ARTICLE 5
INSURANCE AND INDEMNIFICATION

5.1. Indemnification. Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out the negligent or willful performance or non-performance by the indemnifying party, or any

functions, duties or obligations of such party under this Contract. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.2. Insurance Requirements.

Professional/Medical Malpractice:
Hospital providing Covered Services to Members shall maintain a Professional Liability (Medical Malpractice) Insurance policy with minimum limits as follows:

Hospital providing Covered Services:	$5,000,000 per incident/$5,000,000 aggregate

Commercial General Liability/Commercial Automobile Liability:
Each Hospital providing Covered Services to Members shall maintain a Commercial General Liability Insurance policy and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability:	$1,000,000 per occurrence/$3,000,000 aggregate
Commercial Automobile Liability:	$1,000,000 per occurrence/$3,000,000 aggregate

Workers' Compensation:
Hospital providing Covered Services to Members shall maintain a Workers' Compensation Insurance policy with minimum limits as follows:

Employers' Liability Insurance:	$1,000,000 Bodily injury each accident $1,000,000 Bodily injury policy limit $1,000,000 Bodily injury each employee

5.3. Insurance Requirements (continued). Hospital, at their sole cost and expense, shall maintain the above referenced policies as shall be necessary to insure themselves, customers (including Members), 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 performance of any Covered Services provided hereunder; (b) the use of any property and Facilities of the Hospital; and (c) activities performed in connection with the Contract.

5.4. Insurer Ratings. Such insurance shall be provided by an insurer:

(a) rated by A.M. Best with a rating of A V or better; and
(b) "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7

5.5. Captive Risk Retention Group/Self Insured. Where any of the Insurance(s) mentioned by Section 5.2 above are provided by a Captive Risk Retention Group or self-insured, Section 5.4 above may be waived at the sole discretion of CalOptima, but only after review of the Captive Risk Retention Group's or self-insured's audited financial statements.Cancellation or Material Change. The FFS Hospital 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 Contract.Proof of Insurance. Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance shall be provided to CalOptima prior to execution of the Contract and annually thereafter.

ARTICLE 6
RECORDS, AUDITS AND REPORTS

6.1. Access to and Audit of Contract Records. For the purpose of review of items and services furnished under the terms of this Contract and duplication of any books and records, Hospital shall allow CalOptima, its regulators and/or their duly authorized agents and representatives access to said books and records, including medical records, for the purpose of direct physical examination of the records by CalOptima or its regulators and/or their duly authorized agents and representatives at the Hospital's premises. Hospital shall be given advance notice of such visit in accordance with state and federal law, and CalOptima Policies. Such access shall include the right at all reasonable times to evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under this Contract and inspect, audit and reproduce all records and materials and to verify Claims and reports required according to the provisions of this Contract. Hospital shall maintain records in chronological sequence, and in an immediately retrievable form in accordance with the laws and regulations applicable to such record keeping. Hospital shall also comply with any audit and access requirements set forth in the CalOptima Program Addenda, as applicable. All inspections and evaluations shall be performed in such a manner as will not unduly delay the services. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Hospital at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Hospital from participation in the Medi-Cal program; seek recovery of payments made to the Hospital; impose other sanctions provided under the State Plan, and Hospital's contract may be terminated due to fraud.

6.2. Medical Records. Hospital shall establish and maintain for each Member who has obtained Covered Services, medical records which are organized in a manner which contain such demographic and clinical information as is necessary to provide and ensure accurate and timely documentation as to the medical problems and Covered Services provided to the Member. Such medical records shall be consistent with State and Federal laws and CalOptima Program requirements and shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction

of, the Hospital. Such medical records shall be in such a form as to allow trained health professionals, other than the Hospital, to readily determine the nature and extent of the Member's medical problem and the services provided, and to permit peer review of the care furnished to the Member.

6.3. Records Retention. The Hospital shall maintain books and records in accordance with the time and manner requirements set forth in Federal and State laws and CalOptima Programs as identified in the CalOptima Program Addenda to this Contract. Where the Hospital furnishes Covered Services to a Member in more than one CalOptima Program with different record retention periods, then the greater of the record retention requirements shall apply.

6.4. Audit, Review and/or Duplication. Audit, review and/or duplication of data or records shall occur within regular business hours, and shall be subject to Federal and State laws concerning confidentially and ownership of records. CalOptima shall pay all duplication and mailing costs associated with such audits if costs exceed $50 per request.

6.5. Confidentiality of Member Information. Hospital agrees to comply with applicable Federal and State laws and regulations governing the confidentiality of Member medical and other information. Hospital further agrees:

6.5.1 Health Insurance Portability and Accountability Act (HIPAA). Hospital shall comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements. Hospital shall comply with HIPAA requirements, other obligations imposed by Regulatory Agencies, and state laws applicable to the confidentiality of patient medical information. Hospital shall also support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

6.5.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. For the purpose of this Contract, Hospital shall protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.5.3 Declaration of Confidentiality. If Hospital and its Subcontractors have access to computer files or any data confidential by statute, including identification of eligible members, Hospital and Subcontractors agree to sign a declaration of confidentiality in accordance with the applicable Government Contract and in a form acceptable to CalOptima and DHCS, DMHC (MRMIB) and/or CMS, as applicable.

6.6. Data Submission. Hospital shall submit to CalOptima complete, accurate, reasonable, and timely provider data, encounter data, and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

ARTICLE 7
TERM AND TERMINATION

7.1. Term. The term of this Contract shall become effective on the Effective Date and shall remain in effect up to and including June 30, 2020. This Contract shall automatically extend for additional one-year terms upon formal approval by the CalOptima Board of Directors, unless terminated by either party as provided for in this Contract.

7.2. Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Hospital (a) has repeatedly and inappropriately withheld Covered Services to a CalOptima Member(s), (b) has failed to perform its contracted duties and responsibilities in a timely and proper manner including, without limitation, service procedures and standards identified in this Contract, (c) has committed acts that discriminate against CalOptima Members on the basis of their health status or requirements for health care services; (d) has not provided Covered Services in the scope or manner required under the provisions of this Contract; (e) has engaged in prohibited marketing activities; (f) has failed to comply with CalOptima's Compliance Program, including Participation Status requirements; (g) has committed fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; or (h) has materially breached any covenant, condition, or term of this Contract. A termination as described above shall be referred to herein as "Termination for Default." In the event of a Termination for Default, CalOptima shall give Hospital prior written notice of its intent to terminate with a thirty (30)-day cure period if the Termination for Default is curable, in the sole discretion of CalOptima. In the event the default is not cured within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this Article are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. The Hospital shall not be relieved of its liability to CalOptima for damages sustained by virtue of breach of the Contract by the Hospital.

7.3. Termination for Non-Payment. Hospital may terminate if CalOptima stops making all payments to Hospital for Hospital Services. In the event of a termination for Non-Payment, Hospital shall give CalOptima prior written notice of its intent with a thirty (30) day cure period. In the event the Non-Payment is not cured within the thirty (30) day cure period, Hospital may terminate the Contract immediately following such thirty (30) day period.

7.4. Hospital's Appeal Rights. Hospital may appeal CalOptima's decision to terminate the Contract for default as provided in Section 7.2 by filing a complaint pursuant to CalOptima Policies. Hospital shall exhaust this administrative remedy, including requesting a hearing according to CalOptima Policy, and shall comply with applicable CalOptima Policies governing judicial claims, before commencing a civil action. Hospital's rights and remedies provided in this Article shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

7.5. Immediate Termination**.** CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice: (i) the suspension or revocation of any license, certification or accreditation required by Hospital and/or Hospital Agents; (ii) the determination by CalOptima that the health, safety, or welfare of Members is jeopardized by continuation of this Contract; (iii) the imposition of sanctions or disciplinary action against Hospital or against Hospital Agents in their capacities with the Hospital by any Federal or State licensing agency; (iv) termination or non-renewal of any Government Contract; (v) the withdrawal of HHS' approval of the waiver granted to the CalOptima under Section 1915(b) of the Social Security Act. If CalOptima receives notice of termination from any of the Government Agencies or termination of the Section 1915(b) waiver, CalOptima shall immediately transmit such notice to Hospital.

7.6. Termination for Insolvency. If either party becomes insolvent, their obligation is to immediately notify the other party. The other party at its sole option, will have the right to terminate the Contract immediately. In the event of the filing of a petition for bankruptcy by or against either party, that party shall assure that all tasks related to the Contract are performed in accordance with the terms of the Contract.

7.7. Modifications or Termination to Comply with Law. CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by Government Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify Hospital in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements and Hospital shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

7.8. Termination Without Cause. Either party may terminate this Contract, without cause, upon ninety (90) days prior written notice to the other party as provided herein.

7.9. Rate Adjustments. The payment rates may be adjusted by CalOptima during the Contract period to reflect implementation of Federal or State laws or regulations, changes in the State budget, the Government Contract(s) or the Government Agencies' policies, changes in Covered Services and/or by CalOptima Board actions. If the Government Agency(ies) has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Hospital. Notwithstanding any other provision of this Contract, in the event of a rate adjustment under this Section, Hospital shall have the right, within thirty

(30) days of receipt of notice of rate adjustment, to terminate this Contract by providing CalOptima with thirty (30) days written notice of such termination.

7.10. Obligations Upon Termination. Upon termination of this Contract, it is understood and agreed that Hospital shall continue to provide authorized Hospital Services to Members who retain eligibility and who are under the care of Hospital at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. Hospital shall continue to provide Hospital Services to hospitalized Members in accordance with generally accepted medical standards and practices until the earlier of the Member's discharge from Hospital; or alternate coverage is arranged for by CalOptima. Payment for any continued Hospital Services as described in this Section shall be at the contracted rates set forth in Attachment B. Prior to the termination or expiration of this Contract and upon request by CalOptima or one of its Government Agencies to assist in the orderly transfer of Members' medical care, Hospital shall make available to CalOptima and/or such Government Agency, copies of any pertinent information, including information maintained by Hospital necessary for efficient case management of Members. Costs of reproduction shall be borne by CalOptima or the government agency, as applicable.

7.11. Approval by and Notice to Government Agencies. Hospital acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of applicable Federal and/or State agencies. CalOptima, and to the extent that this contract includes the provision of services to Medi-Cal beneficiaries, Hospital shall notify the Federal and/or State agencies of amendments to, or termination of, this Contract. Notice shall be given by first-class mail, postage prepaid to the attention of the State or Federal contracting officer for the pertinent CalOptima Program after CalOptima provides notification of the name of the officer. Hospital acknowledges and agrees that any amendments or modifications shall be consistent with requirements relating to submission to such Federal and/or State agency for approval.

ARTICLE 8
GRIEVANCES AND APPEALS

8.1. Hospital Grievances. CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider, including Hospital, shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policies related to the applicable CalOptima Program(s). Hospital complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract shall be resolved through such system.

8.2. Member Grievances and Appeals. Member grievances, complaints, and/or appeals shall be resolved in accordance with Federal and/or State laws, regulations and Government Guidance and as set forth in CalOptima Policies relating to the applicable CalOptima Program. Hospital agrees to cooperate in the investigation of the issues and be bound by CalOptima's grievance decisions and, if applicable, State and/or Federal hearing decisions or any subsequent appeals.

ARTICLE 9
GENERAL PROVISIONS

9.1. Assignment and Assumption. Hospital acknowledges and agrees that a primary goal of CalOptima is to ensure the provision of quality healthcare services to CalOptima Members and that CalOptima and Hospital have entered into this Contract for the benefit of CalOptima Members. Accordingly, CalOptima retains the rights set forth in this Section. Except as specifically permitted hereunder, this Contract is not assignable by the Hospital, either in whole or in part, without the prior written consent of CalOptima, provided that CalOptima's consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract, assignment includes, without limitation, (a) the change of more than twenty-five percent (25%) of the ownership or equity interest in Hospital (whether in a single transaction or in a series of transactions), (b) the change of more than twenty-five percent (25%) of the directors or trustees of Hospital, (c) the merger, reorganization, or consolidation of Hospital with another entity with respect to which Hospital is not the surviving entity, and/or (d) a change in the management of Hospital from management by persons appointed, elected or otherwise selected by the governing body of Hospital (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

9.2. Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Hospital and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder.

9.3. Force Majeure. Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

9.4. Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima. Hospital shall bring any and all legal proceedings against CalOptima under this Contract in California State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceeding shall be brought in the Central District Court of California.

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

9.6. Independent Contractor Relationship. CalOptima and Hospital agree that the Hospital and any agents or employees of the Hospital in performance of this Contract shall act in an independent capacity and not as officers or employees of CalOptima. Hospital's

relationship with CalOptima in the performance of this Contract is that of an independent contractor. Hospital's personnel performing services under this Contract shall be at all times under Hospital's exclusive direction and control and shall be employees of Hospital and not employees of CalOptima. Hospital shall pay all wages, salaries and other amounts due its employees in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7. No Liability of County of Orange, State of California. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, CalOptima and the Hospital hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefore.

9.8. No Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

9.9. Notices. Any notice required to be given pursuant to the terms and provisions of this Contract, unless otherwise indicated herein, shall be in writing and shall be sent by Certified or Registered mail, return receipt requested, postage prepaid, addressed to the party to whom Notice is to be given, at such party's address set forth below or such other address provided by Notice. Notice shall be deemed given seventy-two (72) hours after mailing.

If to CalOptima:

CalOptima
Chief Operating Officer
505 City Parkway West
Orange, CA 92868

If to Hospital:

_____
Name

_____
Title

_____
Address

_____

9.10. Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

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

9.12. Regulatory Approval. Notwithstanding any other provision of this Contract, the effectiveness of the terms and conditions of this Contract, amendments thereto, and assignments thereof, are subject to the approval of applicable Governmental Agencies and the conditions imposed by such Agencies. In the event that the Government Agencies disapprove any provision of this Contract, or impose any condition not otherwise provided for in this Contract (an "Adverse Action"), Parties shall in good faith negotiate an amendment to this Contract necessary or appropriate to resolve the Adverse Action. If after thirty (30) calendar days the parties are unable to agree on an amendment necessary or appropriate to resolve the Adverse Action, then the Contract shall terminate. The terms of this Agreement shall be binding until amended or the Agreement terminates.

9.13. Authority to Execute. The persons executing this Contract on behalf of the parties attest that they are duly authorized to execute this Contract, and that by executing this Contract, the parties are formally bound.

9.14. Severability. In the event any provision of this Contract is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, by any regulation duly promulgated by the United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

ARTICLE 10
EXECUTION

10.1. This Contract is further subject to the State of California and United States providing funding for the term of this Contract and for the purposes with respect to which it is entered into, and the execution of the Government Contracts and the approval of the Contract by the Government Agencies.

10.2. This Contract shall become effective on July 1st, 2019 (the "Effective Date").

IN WITNESS WHEREOF, the parties have executed this Contract as follows:

Hospital	CalOptima
_____ Signature _____ Print Name _____ Title _____ Date	_____ Signature _____ Print Name _____ Title _____ Date

ATTACHMENT A

HOSPITAL SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1. CalOptima Programs. Hospital shall furnish covered services to eligible members in the following CalOptima Programs:

___X___ Medi-Cal Program
___X___ OneCare Program
___X___ Cal MediConnect Program/OneCare Connect
___X___ PACE Program

ARTICLE 2
HOSPITAL SERVICES

2.1. Hospital is responsible for providing all covered Hospital Services, as authorized by CalOptima or designee, provided that such services are available at Hospital, within Hospital's capacity and capability to provide, and Medically Necessary, including but not limited to:

1. Inpatient hospitalization for medical or surgical treatment in a ward or semi-private accommodation, unless a private room is Medically Necessary;
2. Hospitalization in an intensive care unit or special care unit;
3. Pediatric services;
4. Maternity services;
5. Psychiatric and substance abuse services;
6. Newborn nursery, all levels;
7. Ancillary services and supplies, including laboratory and radiology services;
8. Administration of outpatient prescription drugs (take home medications) in instances where continuation of hospital-based treatment shall not be interrupted: three (3) day supply minimum;
9. Emergency Department Services (as provided in Section 2.3 of this Contract, Emergency Services do not require prior authorization);
10. Outpatient services at Hospital's surgicenter or similar freestanding facility, or in Hospital's outpatient department(s); and
11. Administration of blood, blood plasma, or its derivatives, including cost of blood, blood plasma, or its derivatives.

"Hospital Services" does not include bone marrow or solid organ transplantation or home-administered blood clotting factors for the treatment of hemophilia.

ATTACHMENT B

COMPENSATION

For Covered Services provided to CalOptima Medi-Cal Members under this Contract, CalOptima shall reimburse Hospital, and Hospital shall accept as payment in full from CalOptima the lesser of billed charges or the following amounts:

I. Medi-Cal

Outpatient Services

Outpatient services shall be reimbursed at XXX of Medi-Cal reimbursement rates. Outpatient services not contained in the Medi-Cal fee schedule at the time of service are not reimbursable. Billing must comply with Medi-Cal guidelines.

Inpatient Services

All inpatient facility services shall be paid at XXX of Hospital's then-current California Medi-Cal program APR-DRG rate. Inpatient services include emergency department services when a member is admitted within twenty-four hours of an emergency department visit. Inpatient rates are all inclusive. High cost exclusion items will not be reimbursable. Billing must comply with Medi-Cal guidelines.

Inpatient admissions to the Hospital prior to the effective date of any rate amendment and where the Member is still inpatient on the date of this amendment, shall be paid at the rates in place at the time of admission for the entire length of stay.

II. Medicare Advantage (OneCare)

I. INPATIENT ACUTE CARE
II. INPATIENT PSYCH
III. INPATIENT DETOX
IV. OUTPATIENT CARE

==========

Footnotes:

(1) For Medicare Part A or Part B services provided to CalOptima Medicare Advantage Enrollee Patients, Hospital's compensation shall equal the applicable rate shown on this Attachment B.

(2) Medicare Allowable Rates shall have the following meanings:

a) Inpatient: All inpatient facility services shall be paid at XXX -current Medicare, which shall include applicable DRG, outlier reimbursement (if any) and Medicare allowable pass-throughs (capital expense, etc.). This does not include DGME and IME.
b) Outpatient (except for laboratory services): outpatient surgery facility services and ER shall be paid at XXX of Hospital’s Medicare APC rates.
c) Outpatient laboratory services shall be paid at XXX of the Medicare Fee Schedule for Outpatient Lab.

d) Hospital services without a Medicare Allowable rate will be paid at XXX of Billed Charges.

(3) All physician fees are excluded.

(4) In the event of a contracted rate change, the rate in place at the time of admission is the rate that shall be paid.

III. Cal MediConnect (OneCare Connect)

I. INPATIENT ACUTE CARE
II. INPATIENT PSYCH
III. INPATIENT DETOX
IV. OUTPATIENT CARE

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Footnotes:

(1) For Medicare Part A or Part B services provided to CalOptima Cal MediConnect Enrollees, Hospital's compensation shall equal the applicable rate shown on this Attachment B.

(2) Medicare Allowable Rates shall have the following meanings:

a) Inpatient: All inpatient facility services shall be paid at XXX of Hospital's then-current Medicare Program Rate as though Medicare was the payer, which shall include applicable DRG, outlier reimbursement (if any) and Medicare allowable pass-throughs (capital expense, etc). This does not include DGME and IME.
b) Outpatient (except for laboratory services): outpatient surgery facility services and ER shall be paid at XXX of Hospital's Medicare APC rates.
c) Outpatient laboratory services shall be paid at XXX of the Medicare Fee Schedule for Outpatient Lab.
d) Hospital services without a Medicare Allowable rate will be paid at XXX of Billed Charges.

(3) All physician fees are excluded.

(4) In the event of a contracted rate change, the rate in place at the time of admission is the rate that shall be paid.

IV. PACE

INPATIENT ACUTE CARE
II. INPATIENT PSYCH
III. INPATIENT DETOX
IV. OUTPATIENT CARE

==========

Footnotes:

(1) For Medicare Part A or Part B services provided to CalOptima PACE members, Hospital's compensation shall equal the applicable rate shown on this Attachment B.

(2) Medicare Allowable Rates shall have the following meanings:

a) Inpatient: All inpatient facility services shall be paid at XXX of Hospital's then-current Medicare Program Rate as though Medicare was the payer, which shall include applicable DRG, outlier reimbursement (if any) and Medicare allowable pass-throughs (capital expense, etc). This does not include DGME and IME.
b) Outpatient (except for laboratory services): outpatient surgery facility services and ER shall be paid at XXX of Hospital's Medicare APC rates.
c) Outpatient laboratory services shall be paid at XXX of the Medicare Fee Schedule for Outpatient Lab.
d) Hospital services without a Medicare Allowable rate will be paid at XXX of Billed Charges.

(3) All physician fees are excluded.

(4) In the event of a contracted rate change, the rate in place at the time of admission is the rate that shall be paid.

ATTACHMENT B-1

MEDI-CAL COMPENSATION RATES FOR ADULT EXPANSION MEMBERS

Compensation rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future payments to CalOptima, CalOptima will amend the Contract to adjust payments made to the Hospital.

For Covered Services provided to CalOptima Medi-Cal Adult Expansion Members under this Contract, CalOptima shall reimburse Hospital, and Hospital shall accept as payment in full from CalOptima the lesser of billed charges or the following amounts:

I. Medi-Cal

Outpatient Services

Outpatient services shall be reimbursed at XXX of Medi-Cal reimbursement rates. Outpatient services not contained in the Medi-Cal fee schedule at the time of services are not reimbursable. Billing must comply with Medi-Cal guidelines.

Inpatient Services

All inpatient facility services shall be paid at XXX of Hospital's then-current California Medi-Cal program APR-DRG rate. Inpatient services include emergency department services when a member is admitted within twenty-four (24) hours of an emergency department visit. Inpatient rates are all inclusive. High cost exclusion items will not be reimbursable. Billing must comply with Medi-Cal guidelines.

All inpatient services must be authorized. Inpatient admissions to the hospital prior to the effective date of any rate amendment and where the Member is still inpatient on the date of this amendment, shall be paid at the rates in place at the time of admission for the entire length of the stay.

ATTACHMENT C

DISCLOSURE FORM

_____
Name of Hospital

The undersigned hereby certifies that the following information regarding

_____ (the "Hospital") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

_____

_____

Co-Owner(s):

_____

_____

Stockholder(s) owning more than five percent (5%) of the Hospital's stock:

_____

_____

Major creditor(s) holding more than five percent (5%) of the Hospital's debt:

_____

_____

Form of Hospital (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

_____

_____

Dated: _____ Signature: _____

Name: _____
(Please type or print)

Title: _____
(Please type or print)

ADDENDUM 1
MEDI-CAL PROGRAM

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medi-Cal Program (COD and Health Network Members): These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Records Retention. [State Contract, Ex. A, Att. 6, § 12(B)(7)] Hospital shall maintain and retain all records of all items and services provided to Members for a term of at least ten (10) years from the final date of the contract between CalOptima and DHCS or from the date of completion of any audit, whichever is later. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Hospital's books and records shall be maintained within or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Hospital's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

   Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Hospital shall, upon request, transfer copies of such records to CalOptima's possession.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

2. Access to Books and Records. [State Contract, Ex. A, Att. 6, § 12(B)(7)] Hospital agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of Contract, available for purpose of an audit, inspection, evaluation, examination and/or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima, the Government Agencies, CalOptima's Regulators, DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, (b) at all reasonable times at the Hospital's place of business or such other mutually agreeable location in California, and (c) in a form maintained in accordance with general standards applicable to such book or record keeping, for a term of at least ten (10) years from the final date of the contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later, in which the records or data were created or applied, and for which the financial record was completed, and including, if applicable, all Medi-Cal 35 file paid claims data and encounter data for a period of at least ten (10) years from the date of expiration or termination. Hospital shall provide access to all security areas and shall provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties.

   Hospital shall cooperate in the audit process by signing any consent forms or documents required by but not limited to; DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima to release any records or documentation Hospital may possess in order to verify Hospital's records.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise

3. Form of Records. [State Contract, Ex. A, Att. 6, § 12(B)(7)] Hospital's and its Subcontractors' books and records shall be maintained in accordance with the general standards applicable to such book or record-keeping.

4. Third Part Tort Liability/Estate Recovery. [State Contract, Ex. E, Att 2 § 22] Hospital shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, or casualty liability insurance awards and uninsured motorist coverage. Hospital shall identify and notify CalOptima, within five (5) calendar days of discovery, which shall in turn notify DHCS, of any action by the CalOptima Member involving the Tort Workers' Compensation liability of a third party or estate recovery that could result in recovery by the CalOptima Member of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code.

5. Records Related to Recovery for Litigation. [State Contract, Ex. A, Att. 6, § 12(B)(15), Ex. E, Att. 2, § 23]

5.1. Upon request by CalOptima, Hospital shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Hospital's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Hospital asserts that any requested documents are covered by a privilege, Hospital shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Hospital acknowledges that time may be of the essence in responding to such request. Hospital shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Hospital or its Subcontractors related to this Contract or Subcontracts entered into under this Contract.

5.2. In addition to the payments provided for elsewhere in this Contract, CalOptima agrees to pay Hospital for complying with Paragraph 5.1, above, as follows:

5.2.1. CalOptima shall reimburse Hospital amounts paid by Hospital to third parties for services necessary to comply with Paragraph 5.1. Any third party assisting Hospital with compliance with Paragraph 5.1 shall comply with all applicable confidentiality requirements. Amounts paid by Hospital to any third party for assisting Hospital in complying with Paragraph 5.1, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by CalOptima.

5.2.2. If Hospital uses existing personnel and resources to comply with Paragraph 5.1, CalOptima shall reimburse Hospital as specified below. Hospital shall maintain and provide to CalOptima time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by CalOptima.

5.2.2.1. Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to Paragraph 5.1.

5.2.2.2. Costs for copies of all documentation submitted to CalOptima pursuant to paragraph 5.1, subject to a maximum reimbursement of ten (10) cents per copied page.

5.2.3. Hospital shall submit to CalOptima all information needed by CalOptima to determine reimbursement to Hospital under this provision, including, but not limited to, copies of invoices from third parties and payroll records.

6. Medical Records. [State Contract, Ex. A, Att. 4, § 13] All medical records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1936a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Hospital shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Participating Provider site.

7. Downstream Contracts. [State Contract, Ex. A, Att. 6, § 12(B)(9)] In the event that Hospital is allowed to subcontract for services under this Contract, and does so subcontract, then Hospital shall, upon request, provide copies of such Subcontracts to CalOptima or DHCS.

8. (This section left intentionally blank).

9. Changes in Availability or Location of Services. [State Contract, Ex. A, Att. 9, § 9] Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Hospital's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

10. Confidentiality of Medi-Cal Members. [State Contract, Ex. D(F) § 13; Ex. E, Att. 2, § 19] Hospital and its employees, or agents shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Hospital, its employees, or agents as a result of services performed under this Contract, except for statistical information not identifying any such person. Hospital and its employees, or agents shall not use such identifying information for any purpose other than carrying out Hospital's obligations under this Contract.

Hospital and its employees, or agents shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Hospital shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Hospital from unauthorized disclosure. Hospital may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Contractor is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Hospital, Hospital:

10.1. will not use any such information for any purpose other than carrying out the express terms of this Contract,

10.2. will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

10.3. will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

10.4. will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Hospital by CalOptima for this purpose.

11. Debarment Certification. [State Contract, Ex. D(F), § 19] By signing this Contract, the Hospital agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

11.1. By signing this Contract, the Hospital certifies to the best of its knowledge and belief, that it and its principals:

11.1.1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

11.1.2. Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission

of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

11.1.3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Subprovision 11.1.2 herein; and

11.1.4. Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

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

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

11.2. If the Hospital is unable to certify to any of the statements in this certification, the Contractor shall submit an explanation to CalOptima.

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

11.4. If the Hospital knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

12. DHCS Directions. [State Contract, Ex. E, Att. 2, § 15] If required by DHCS, Hospital shall cease specified activities for CalOptima Members, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

13. Air or Water Pollution Requirements. [State Contract, Ex. D(F), § 11] Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Hospital agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

14. Lobbying Restrictions and Disclosure Certification. [State Contract, Ex. D(F), § 31]

14.1. (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

14.2. Certification and Disclosure Requirements

14.2.1. Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1 to this Addendum 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Subsection 14.3 of this provision.

14.2.2. Each recipient shall file a disclosure (in the form set forth in Attachment 2 to this Addendum 1, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

14.2.3. Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 14.2.2 herein. An event that materially affects the accuracy of the information reported includes:

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

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

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

14.2.4. Each person (or recipient) who requests or receives from a person referred to in Paragraph 14.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

14.2.5. All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 14.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

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

15. Additional Subcontracting Requirements. [State Contract, Ex. A, §12(B)(11)]

15.1. Hospital shall ensure that all Subcontracts are in writing and require that the Hospital and its Subcontractors:

15.1.1. Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima, DHCS, CalOptima's Regulators, and/or DOJ, or their designees.

15.1.2. Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the State Contract period or from the date of completion of any audit, whichever is later.

15.2. Hospital shall require all Subcontracts that relate to the provision of Medi-Cal Covered Services to Members pursuant to the Contract include the following:

15.2.1. Services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

15.2.2. Subcontract or its amendments are subject to DHCS approval as provided in the State Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract.

15.2.3. An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 6.5.3 or the Contract, which shall be signed and filed with DHCS prior to the Subcontractor being allowed access to computer files or any other data or files, including identification of Members.

15.2.4. An agreement that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 21 of this Addendum 1.

15.2.5. An agreement to submit provider data, encounter data, and reports related to the Subcontract in accordance with Sections 2.36 and 6.6 of the Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Section 5 and 22 of this Addendum 1.

15.2.6. An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for purpose of an audit, inspection, evaluation, examination, or copying, in accordance with Section 6.1 of the Contract and Sections 2 and 16 of this Addendum 1.

15.2.7. An agreement to maintain and make available to DHCS, CalOptima, and/or Hospital, upon request, all sub-subcontracts related to the Subcontract, and eto ensure all sub-contractors are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 15.1 of this Addendum 1.

15.2.8. An agreement to comply with CalOptima's Compliance Program (including, without limitations, CalOptima Policies), all applicable requirements or the DHCS Medi-Cal Managed Care Program, and all monitoring provisions and requests set forth in Section 17 of this Addendum 1.

15.2.9. An agreement to assist Hospital and/or CalOptima in the transfer of care of a Member in the event of termination of the State Contract or the Contract for any reason, in accordance with Section 19 of this Addendum 1, and in the event of termination of the Subcontract for any reason.

15.2.10. An agreement to hold harmless the State, Members, and CalOptima in the event the Hospital cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.6 of the Contract.

15.2.11. An agreement to notify DHCS in the manner provided in Section 7.11 of the Contract in the event the Subcontract is amended or terminated.

15.2.12. An agreement to the provision of interpreter services to Members at all provider sites as set forth in Section 2.29 of the Contract, to comply with the language assistance standards developed pursuant to Health and Safety Code section 1367.04, and to the requirements for cultural and linguistic sensitivity as set forth in Section 2.28 or the Contract.

15.2.13. Subcontractor shall have access to CalOptima's dispute resolution mechanism in accordance with Section 8.1 of the Contract for issues arising under the Subcontract related to the provision of Medi-Cal services to CalOptima Medi-Cal members, as provided in CalOptima Policies relative to the Medi-Cal Program, and excluding any contract

disputes between Hospital and Subcontractor, particularly regarding, but not limited to, payment for services under the Subcontract.

15.2.14. An agreement to participate and cooperate in quality improvement system as set forth in Section 2.25 of the Contract, and to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies in instances where DHCS, CalOptima and/or Hospital determines that the Subcontractor has not performed satisfactorily.

15.2.15. If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Section 25 of this Addendum 1 and Section 6.5.3 of the Contract.

15.2.16. An agreement by the Hospital to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 7.7. of the Contract.

15.2.17. An agreement for the establishment and maintenance of and access to medical and administrative records as set forth in Sections 6.2 and 6.3 of the Contract and Sections 1, 3 and 6 of this Addendum 1.

15.2.18. An agreement that Subcontractors shall notify Hospital of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

16. State's Right to Monitor. Authorized State and Federal agencies will have the right to monitor, inspect or otherwise evaluate all aspects of the Hospital's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring, inspection or evaluation activities will include, but are not limited to, inspection and auditing of Hospital, Subcontractor, and provider facilities, management systems and procedures, and books and records as the Director of DHCS deems appropriate, at anytime, pursuant to 42 CFR Section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Hospital. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by authorized State agencies will have access to all security areas and the Hospital will provide, and will require any and all of its subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Hospital and/or the subcontractor(s).

17. Hospital shall comply with all monitoring provisions of this Contract and the State Contract between CalOptima and DHCS, and any monitoring requests by CalOptima and DHCS.

18. Hospital shall comply with language assistance standards developed pursuant to Health & Safety Code Section 1367.04.

19. Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's State Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor State contractor, the Hospital shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

20. This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract between CalOptima and DHCS.

21. Hospital agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Hospital or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change or more than twenty-five percent (25%) of the directors of trustees of Hospital of Subcontractor; (iii) the merger, reorganization, or consolidation of Hospital or Subcontractor, with another entity with respect to which Hospital or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Hospital or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Hospital or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

22. Hospital further agrees to timely gather, preserve, and provide to DHCS any records in the Hospital's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

23. Hospital agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason.

24. Notwithstanding anything in this Contract to the contrary, Hospital shall be entitled to the protections of the Health Care Providers' Bill of Rights, California Health and Safety Code section 1375.7, in the administration of this Contract relative to the Medi-Cal program.

25. If and to the extent that the Hospital is responsible for the coordination of care for Members, CalOptima shall share with Hospital, in accordance with the appropriate Declaration of Confidentiality signed by Hospital and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and Hospital shall receive the utilization data provided by CalOptima and use it as the Hospital is able for the purpose of Members care coordination.

26. Hospital shall hold harmless both the State and Members in the event that CalOptima cannot or will not pay for services performed by the Hospital pursuant to the Contract.

Addendum 1--Attachment 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

Addendum 1--Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB

0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier, if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	13. Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

ADDENDUM 2
MEDICARE ADVANTAGE PROGRAM
(ONECARE)

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medicare Advantage Program (OneCare):

1. Record Retention. Hospital agrees to retain books, records, Member medical, Subcontractor and other records for at least ten (10) years from the final date of the Contract, or from the completion of any audit, whichever is later unless a longer time is required under MA regulations.

2. Right of Inspection, Evaluation, Audit of Records. Hospital and its Subcontractors agree to maintain and make available contracts, books, documents, and records involving transactions related to the Contract to CalOptima, DMHC, HHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory or accrediting organizations or their designees to inspect, evaluate, and audit for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to above, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Hospital's provision of health care services to Members, the cost of such services, and payments received by Hospital from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

3. Accountability Acknowledgement. Hospital further agrees and acknowledges that CalOptima oversees and is accountable to CMS for functions or responsibilities described in MA regulations; that CalOptima may only delegate activities or functions in a manner consistent with the MA program delegation requirements; and that any services or other activities performed by Hospital pursuant to the Contract are consistent and comply with CalOptima's contractual obligations with CMS and adhere to delegation requirements set forth by MA statutes, regulations and/or other guidance. Where delegated responsibilities are identified in this Contract, the following shall apply:

    3.1. Delegation by CalOptima. Hospital warrants that it meets CalOptima delegation criteria set forth in the Attachment to this Contract and agrees to accept delegated responsibility for those listed activities. Hospital agrees to perform the delegated activities in a manner consistent with the delegation criteria. Hospital agrees to notify CalOptima of any change in its eligibility under the delegation criteria within twenty-four (24) hours from the date it fails to meet such delegation criteria. Hospital acknowledges that delegation to another entity does not alter Hospital's ultimate obligations and responsibilities set forth in this Contract. Hospital acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly

delegated herein by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

3.2. Reports on Delegated Activities. Hospital agrees to provide CalOptima with periodic reports on delegated activities performed by Hospital as provided in the delegation criteria. The report shall be in a form and contain such information as shall be agreed upon between the parties. Hospital agrees to take those corrective actions identified by CalOptima through the audit review process.

3.3. CalOptima Oversight of Delegation. The delegation of the functions and responsibilities stated herein does not relieve CalOptima of any of its accountability to CMS and obligations to its Members under applicable law. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations by Hospital, which will be monitored by CalOptima on an ongoing basis. In the event Hospital breaches its obligation to perform any delegated duties, CalOptima shall have all remedies set forth in this Contract, including, but not limited to, penalties or termination of the delegation of such functions to Hospital as set forth in this Contract. Moreover, CalOptima shall have the right to require Hospital to terminate any Subcontracting Hospital for good cause, including but not limited to breach of its obligations to perform any delegated duties.

3.4. Review of Credentials. Hospital shall ensure that the credentials of medical professionals affiliated with the Hospital are reviewed by it. Hospital agrees that CalOptima will review and approve Hospital's credentialing process on ongoing basis.

4. COB Requirements.

(a) MSP Obligations. Hospital agrees to comply with MSP requirements. Hospital shall coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third party liens such charges for which the other payer is responsible. Hospital agrees to establish procedures to effectively identify, at the time of service and as part of their claims payment procedures, individuals and services for which there may be a financially responsible party other than MA Program. Hospital will bill and collect from other payers such amounts for Covered Services for which the other payer is responsible.

(b) Hospital Authority to Bill Third Party Payers. Hospital may bill other individuals or entities for Covered Services for which Medicare is not the primary payer, as specified herein. If a Medicare Member receives from Hospital Covered Services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, Hospital may bill any of the following— (1) the insurance carrier, the employer, or any other entity that is liable for payment for the services under Section 1862(b) of the Act and 42 C.F.R. part 411 or (2) the Medicare enrollee, to the

extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

5. Reporting Requirements. Hospital shall comply with CalOptima's reporting requirements in order that it may meet the requirements set forth in MA laws and regulations for submitting encounter and other data including, without limitation, 42 CFR § 422.516. Hospital also agrees to furnish medical records that may be required to obtain any additional information or corroborate the encounter data.

6. Submission and Prompt Payment of Claims. Hospital agrees to submit claims to CalOptima in such format as CalOptima may require (but at minimum the CMS forms 1500, UB 92 or other form as appropriate) within ninety (90) days after the services are rendered. CalOptima reserves the right to deny claims that are not submitted within ninety (90) days of the date of service, except where Hospital bills a third party payor as primary. Hospital agrees to refrain from duplicate billing any claims submitted to CalOptima, unless expressly approved by CalOptima in order to process coordination of benefit claims. CalOptima shall provide payment to Hospital within forty-five (45) business days of CalOptima's receipt of a clean and uncontested claim from Hospital, or, CalOptima will contest or deny Hospital's claim within forty-five (45) business days following CalOptima's receipt thereof.

7. Provider Terminations. In the event a provider intending to become a Participating Provider is denied medical staff privileges at the Hospital or a Participating Provider is suspended or removed from the medical staff, Hospital shall provide the provider with written notice of the reason for the action as required by Federal and State laws. In the event Hospital terminates a Participating Provider's medical staff membership for deficiencies in the quality of care provided, Hospital shall give notice of the action to the appropriate licensing and disciplinary agencies.

8. Prohibited Interference With Enrollment Relationships. Hospital agrees that it will not: (a) violate any laws and regulations governing the solicitation of CalOptima Enrollees; (b) encourage or seek to have an Enrollee disenroll from CalOptima and/or enroll in (i) another health maintenance organization, including one in which Hospital has an ownership interest, (ii) another managed care plan, (iii) a case management arrangement, or (iv) any other similar arrangement, including any other arrangement in which Hospital has a direct or indirect ownership interest (collectively referred to as "Alternative Care Plan"); and/or (c) interfere with the enrollment of CalOptima Enrollees. Any such activity would constitute a material breach of this contract. The provisions of this Section shall apply to all Hospital employees and subsidiaries and affiliates of Hospital, including any such arrangements established after the Effective Date of this Contract. Nothing in this Section shall prohibit Hospital from providing information to the public as to its affiliation with an Alternative Care Plan, so long as such activities do not include any of the prohibited activities set forth above. Both parties agree that if a dispute arises as to whether there has been a breach of this Section it shall be resolved in accordance with the dispute resolution section of this Agreement, set forth in Article XIII.

9. Medical Decision-Making. It is not the intention of CalOptima to use the preauthorization and approval provisions set forth herein as a device by which it may practice medicine. Rather, the authorization and approval procedures are used to make benefit and coverage determinations so that the Member and Participating Providers know, before a course of treatment is initiated, that such course of treatment is covered in full, in part or not at all. If a course of treatment is not covered, *e.g.*, not approved, such determination is not intended to suggest that the course of treatment is medically inappropriate. CalOptima will notify the attending Physician (Specialist Physician) and, if applicable; the primary care physician, of a denial of coverage; however, Physicians and/or Hospital may choose to provide such course of treatment, so long as prior written notice is given to the Member that the course of treatment is not covered by CalOptima. Hospital may bill a Member for Non-Covered Services, but may not bill a Member for Covered Services which are not Medically Necessary.

10. Retroactive Denials of Payment and Recoupment. When CalOptima is notified of retroactive disenrollments of Members, or when CalOptima obtains information or data that contradicts its reliance that caused its authorization for Hospital Services, CalOptima may retroactively deny Hospital Services furnished to Members, and shall send immediate written notice of such denial to Hospital. Hospital shall recognize CalOptima's immediate right to recovery for retroactively disenrolled Members who were disenrolled no earlier than thirty (30) days prior to the date of service at the Hospital, and shall refund contested paid claims within forty-five (45) working days of notice from CalOptima. CalOptima may recoup, per CalOptima policy, any such amounts in the event that Hospital does not repay such amounts as provided above. Other than as provided for above, should the Hospital follow correct CalOptima authorization procedures, and Hospital receives an authorization from CalOptima to provide Hospital Services to a Member, CalOptima shall be liable to reimburse Hospital per the terms and conditions of this Contract. Under no circumstances shall payment be denied for such previously authorized services based on retroactive Medical Necessity determinations. This clause shall not be construed to limit CalOptima's right to recoup payments made to the Hospital on any other basis for which recoupment is appropriate.

11. Use of Hospital Name. CalOptima may use Hospital's name for advertising/marketing purposes, but may not use Hospital's trademarks or logos without prior written permission.

ADDENDUM 3

CAL MEDICONNECT PROGRAM REQUIREMENTS

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Cal MediConnect Program. These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Hospital shall provide services or perform other activity pursuant in the Contract in accordance with (i) applicable DHCS and CMS laws, regulations and instructions, including, but not limited to 42 CFR Sections 422.504, 423.505, 438.3(k), and 438.414, (ii) contractual obligations with CalOptima, and (iii) CalOptima's contractual obligations to CMS and DHCS, .

2. Hospital shall (i) safeguard Enrollee privacy and confidentiality of Enrollee (ii) comply with all Federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information, (iii) ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (iv) maintain the records and information in an accurate and timely manner, (v) ensure timely access by Enrollees to the records and information that pertain to them, and (vi) comply with all DHCS and CMS confidentiality requirements.

3. The performance of the Hospital and its Downstream Entities is monitored by CalOptima on an ongoing basis and CalOptima may impose corrective action as necessary. Hospital shall comply with all CalOptima and DHCS monitoring of performance and any monitoring requests by CalOptima and DHCS.

4. Hospital shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities, monitoring, and, public reporting to consumers as identified in CalOptima policy.

5. Hospital shall submit timely and accurate encounter data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

6. Hospital acknowledges and agrees that medical providers' Emergency Medical Treatment and Active Labor Act (EMTALA) obligations shall not create any conflicts with Hospital actions required to comply with EMTALA.

7. Hospital shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. Hospital shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Hospital shall, in its policies, administration, and services, practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual

differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff and Subcontractors attitudes and interpersonal communication styles that respect Members' cultural and ethnic backgrounds. Hospital shall provide translation of written materials in the Threshold Languages and Concentration Languages identified by CalOptima at no higher than the sixth (6^{th}) grade reading level.

8. Hospital shall not close or limit their practice or acceptance of CalOptima Members as patients unless the same limitations apply to all commercially insured Members as well.

9. Hospital shall not be prohibited from communicating or advocating on behalf of a Member who is a prospective, current, or former patient of the Hospital. Hospital may freely communicate the provisions, terms or requirements of CalOptima's health benefit plans as they relate to the needs of such Member; or communicate with respect to the method by which such Hospital is compensated by CalOptima for services provided to the Member. CalOptima will not refuse to contract or pay Hospital for the provision of covered services under the CalOptima Cal MediConnect Program solely because Hospital has in good faith communicated or advocated on behalf of a Member as set forth above.

10. CMS Participation Requirements. Provider represents and warrants that: (i) neither Provider nor any of its employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("Federal Health Care Program(s)"); (ii) Provider has not arranged or contracted with (by employment or otherwise) with any employee, contractor or agent that Provider knows or should know are excluded from participation in Federal Health Care Programs; (iii) no action is pending against Provider or any of its employees or agents performing services under this Contract to suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) Provider agrees to immediately notify CalOptima in the event that it learns that it is or has employed or contacted with a person or entity that is excluded from participation in any Federal Health Care Program. In the event Provider fails to comply with the above, CalOptima reserves the right to require Provider to pay immediately to CalOptima, the amount of any sanctions or other penalties that may be imposed on CalOptima by DHCS and/or CMS for violation of this prohibition, and shall be responsible for any resulting overpayments.

11. Downstream Entity Contracts.

11.1. If any services under this Contract are to be provided by a Downstream Entity on behalf of Hospital, Hospital shall ensure that such subcontracts are in compliance with 42 CFR Sections 422.504, 423.505, , 438.3(k), 438.414 and 438.6(1). Such subcontracts shall include all language required by DHCS and CMS as provided in this Contract, including but not limited to, the following:

11.1.1. An agreement that any services or other activity performed under the subcontract shall comply with Section 1 of this Addendum 3 and Section 2.32 of the Contract.

11.1.2. An agreement to (i) Enrollee financial protections in accordance with Section 4.6 of the Contract, including prohibiting Downstream Entities from holding an Enrollee liable for payment of any fees that are the obligation of the Hospital, and (ii) safeguard Enrollee privacy and confidentiality of Enrollee health records.

11.1.3. An agreement to comply with the inspection, evaluation, and/or auditing requirements of Section 12 of this Addendum 3 and the reporting requirements of Section 5 of this Addendum 3.

11.1.4. An agreement to (i) the revocation of the delegation activities and related reporting requirements or other specified remedies in accordance with Section 13 of this Addendum 3 and 2.27 of the Contract, and (ii) monitoring and corrective action in accordance with Section 3 of this Addendum 3.

11.1.5. If the subcontract is for credentialing of medical providers, an agreement to the requirements of Section 14 of this Addendum 3.

11.1.6. An agreement to provide a written statement to provider of the reason(s) for termination for cause as set forth in Section 15 of this Addendum 3.

11.2. In addition to Section 11.1 of this Addendum 3, Hospital shall further ensure any subcontracts with its Downstream Entities for medical providers include the following:

11.2.1. Term of the subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received from the Hospital.

11.2.2. An agreement that the contracted medical providers are paid under the terms of the Subcontract, including but not limited to, a mutually agreeable prompt payment provision.

11.2.3. An agreement that services are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds, in accordance with Section 7 of this Addendum 3.

11.2.4. An agreement to comply with (i) the confidentiality requirements of Enrollee records and information in accordance with Section 2 of this Addendum 3, and (ii) EMTALA obligations as set forth in Section 6 of this Addendum 3.

11.2.5. An agreement that (i) providers shall not close or otherwise limit their acceptance of Enrollees as patients unless the same limitations apply to all

commercially insured enrollees, and (ii) Enrollees shall not be held liable for Medicare Part A and B cost sharing in accordance with Section 4.6.1 of the Contract and Section 20 of this Addendum.

11.2.6. An agreement regarding (i) provider communication or advocacy on behalf of Members as set forth in Section 9 of this Addendum 3, and (ii) specified circumstances where indemnification is not required by provider as set forth in Section 17 of this Addendum 3.

11.2.7. An agreement that the medical provider assist the Hospital and/or CalOptima in the transfer of care of a Member in accordance with Section 16 of this Addendum.

11.2.8. An agreement (i) that the assignment or delegation of the subcontract will be void unless prior written approval is obtained pursuant to Section 18 of this Addendum 3, and (ii) to notify DHCS in the manner set forth in Section 7.11 of the Contract in the event the subcontract is amended or terminated.

11.2.9. An agreement to (i) gather, preserve, and provide records as set forth in Section 19 of Addendum 3, and (ii) provider's right to submit a grievance in accordance with Section 8.1 of the Contract.

11.2.10. An agreement to (i) participate and cooperate in quality improvement system as set forth in Section 2.25 of the Contract, and (ii) the provision of interpreter services for Enrollees at all provider sites in accordance with Section 2.29 of the Contract.

12. Right of Inspection, Evaluation, and Audit of Records. Hospital and its Downstream Entities agree to maintain and make available contracts, books, documents, records, computer, other electronic systems, medical records, and any pertinent information related to the Contract to CalOptima, DMHC, HHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory or accrediting organizations or their designees to inspect, evaluate, and audit for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to above, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Hospital's provision of health care services to Members, the cost of such services, and payments received by Hospital from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

13. Hospital and its Downstream Entities agree to the revocation of the delegation of activities or obligations and related reporting requirements or other remedies set forth in Section 2.27 of the Contract in instances where CMS, DHCS, and/or CalOptima

determines that the Hospital and/or its Downstream Entities have not performed satisfactorily.

14. Review of Credentials. Hospital shall ensure that the credentials of medical professionals affiliated with the Hospital are reviewed by it. Hospital agrees that CalOptima will review, approve, and audit Hospital's credentialing process on ongoing basis.

15. Provider Terminations. In the event a provider intending to become a Participating Provider is denied medical staff privileges at the Hospital or a Participating Provider is suspended or removed from the medical staff, Hospital shall provide the provider with written notice of the reason for the action as required by Federal and State laws. In the event Hospital terminates a Participating Provider's medical staff membership for deficiencies in the quality of care provided, Hospital shall give notice of the action to the appropriate licensing and disciplinary agencies.

16. In addition to Section 2.7 of the Contract, Hospital agrees to assist CalOptima in the transfer of care of a Member. Hospital shall further assist CalOptima in the transfer of care of a Member in the event of Subcontract termination for any reason.

17. Hospital is not required to indemnify CalOptima for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against CalOptima based on CalOptima's management decisions, utilization review provisions, or other policies, guidelines, or actions relative to CalOptima Cal MediConnect Program.

18. Assignment or Delegation. Hospital agrees that the assignment or delegation of this Contract or subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Hospital or Downstream Entity (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors of trustees of Hospital or Downstream Entity; (iii) the merger, reorganization, or consolidation of Hospital or Downstream Entity, with another entity with respect to which Hospital or Downstream Entity is not the surviving entity; and/or (iv) a change in the management of Hospital or Downstream Entity from management by persons appointed, elected or otherwise selected by the governing body of Hospital or Downstream Entity (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

19. Hospital agrees to timely gather, preserve, and provide to DHCS or CalOptima, as applicable, any records in the Hospital's or its Subcontractor's possession.

20. In addition to Section 4.6.1 of the Contract, Hospital acknowledges and agrees that Medicare Parts A and B services shall be provided at zero-cost sharing to Enrollees.

Addendum 3--Attachment 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

Addendum 3--Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB

0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier, if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): b. cash b. in-kind, specify: Nature Value	13. Type of Payment (check all that apply): b. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:

16. 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:

17. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

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INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.
10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

ADDENDUM 4
PACE PROGRAM REQUIREMENTS

The terms and requirements of this Addendum 4 shall apply for services provided by Provider to Members who are enrolled in the CalOptima PACE program only.

1. State Approval and Termination.

   1.1. This Addendum to the Contract shall not become effective until approved in writing by the California Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services, (CMS), or by operation of law where DHCS and CMS have acknowledged receipt, verbally or in writing, and has failed to approve or disapprove the proposed contract within sixty (60) days of receipt.

   1.2. Amendments to this Contract and amendments to any subcontract agreements between Provider and subcontractor shall be submitted to DHCS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved nor disapproved by DHCS shall become effective by operation of law within thirty (30) days after DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later.

   1.3. CalOptima may terminate this Contract as it applies to providing services to CalOptima PACE participants if CalOptima's PACE Agreement or State Medi-Cal contract is terminated for any reason. CalOptima shall notify Provider of any such termination immediately upon its provision of notice of termination of the PACE Agreement or State Medi-Cal contract, or upon receipt of a notice of termination of the PACE Agreement from DHCS/CMS, or the State Medi-Cal Contract from DHCS.

2. Provider's Responsibilities applicable to providing services to CalOptima PACE enrollees.
   Provider shall be accountable to CalOptima in accordance with the terms of this Contract.
   For CalOptima PACE enrollees, Provider agrees to do the following:

   2.1. Provider shall make available a location that is accessible to PACE participants within the PACE service area of Orange County, California.

   2.2. Duties Related to Provider's Position. Provider shall perform all the duties related to its position, as specified in this Contract.

   2.3. Services Authorized. Provider shall furnish only those services authorized by the CalOptima PACE Interdisciplinary Team (IDT); PCP referral is deemed as an IDT authorization.

   2.4. Interdisciplinary Team Meeting Participation. If necessary for the benefit of a CalOptima PACE participant's care delivery or planning, Provider shall participate in CalOptima PACE Interdisciplinary Team meetings as required. Such participation may

be by telephone, unless in-person attendance at such meetings is reasonably warranted under the circumstances.

2.5. Payment in Full. Provider shall accept CalOptima's payment as payment in full, and shall not seek any reimbursement for services directly from the CalOptima PACE member, Medi-Cal, Medicare or other insurance carrier or provider. Provider shall not seek any type of copayment from PACE member for Covered Services. CalOptima PACE participants shall not be liable to Provider for any sum owed by CalOptima, and Provider agrees not to maintain any action at law or in equity against CalOptima PACE participants to collect sums that are owed by CalOptima. Surcharges to CalOptima PACE participants by Provider are prohibited. Whenever CalOptima receives notice of any such surcharge, CalOptima shall take appropriate action, and Contractor shall reimburse the participant as appropriate.

2.6. Hold Harmless. In accordance with the Medi-Cal Contract and the PACE Agreement, Provider will not bill the State of California, CMS or CalOptima PACE participants in the event CalOptima cannot or will not pay for services performed by Provider pursuant to this Contract.

2.7. Reporting. Provider shall provide such information and written reports to CalOptima, DHCS, and DHHS, as may be necessary for compliance by CalOptima with its statutory obligations, and to allow CalOptima to fulfill its contractual obligations to DHCS and CMS.

2.8. Coverage of Non-Network Providers. Provider agrees that should arrangements be made by Provider with another physician/provider who is not under contract with CalOptima to provide Covered Services required under this Contract, such physician/provider shall (a) accept Provider's fees from CalOptima as full payment for services delivered to CalOptima PACE participants, (b) bill services provided through Provider's office, unless Provider has made other billing arrangements with CalOptima, (c) not bill CalOptima PACE participants directly, under any circumstances, and (d) cooperate with and participate in CalOptima's quality assurance and improvement program.

2.9. Participant Bill of Rights. Provider shall cooperate and comply with the CalOptima PACE Participant Bill of Rights. A copy of the CalOptima PACE Participant Bill of Rights is attached. CalOptima may, at its sole discretion, make reasonable changes to this document from time to time, and a copy of the revised document will be sent to Provider.

2.10. Provision of Direct Care Services to PACE Participants. Provider hereby represents and warrants that Provider and all employees of Provider providing direct care to CalOptima PACE participant shall, at all time covered by this Contract, meet the requirements set forth in this Section. Provider agrees to cooperate with CalOptima PACE's competency evaluation program and direct participant care requirements, and to notify CalOptima immediately if Provider or any employee of Provider providing services to CalOptima PACE participants no longer meets any of these requirements.

All providers of direct care services to CalOptima PACE Members shall meet the following requirements:

2.10.1. Comply with any State or Federal requirements for direct patient care staff in their respective settings;
2.10.2. Meet Medicare, Medi-Cal and CalOptima requirements applicable to the services Provider furnishes;
2.10.3. Have verified current certifications or licenses for their respective positions;
2.10.4. Have not been excluded from participation in Medicare, Medicaid or Medi-Cal;
2.10.5. Have not been convicted of criminal offenses related to their involvements with Medicare, Medicaid, Medi-Cal, or other health insurance or health care programs, or any social service programs under Title XX of the Act;
2.10.6. Not pose a potential risk to CalOptima PACE participants because of a conviction for physical, sexual, drug or alcohol abuse;
2.10.7. Be free of communicable diseases, and up to date with immunizations, before performing direct patient care; and
2.10.8. Participate in an orientation to the PACE program presented by CalOptima PACE, and agree to abide by the philosophy, practices and protocols of CalOptima PACE.

2.11. The CalOptima PACE program director or his or her designee shall be designated as the liaison to coordinate activities between Provider and PACE.

3. Records Retention. Provider and its Subcontractors shall maintain and retain all records, including encounter data, of all items and services provided Members for ten (10) years from the close of the latest DHCS fiscal year in which the date of service occurred, in which the records or data were created or applied, and for which the financial record was completed. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's and its Subcontractors' books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Provider's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable, and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Provider shall, upon request, transfer copies of such records to CalOptima's possession.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

4. Access to Books and Records. Provider and its Subcontractors agree to make all of its books and records pertaining to the goods and services furnished under, or in any way pertaining to, the terms of Contract and any Subcontract, available for inspection, examination and copying by the Government Agencies, including the DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, at all reasonable times at the Provider's or Subcontractor's place of business or such other mutually agreeable location in California, in a form maintained in accordance with general standards applicable to such book or record keeping. Provider shall provide access to all security areas and shall provide and require Subcontractors to provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties.

   Provider and its Subcontractors shall cooperate in the audit process by signing any consent forms or documents required to effectuate the release of any records or documentation Provider may possess in order to verify Provider's records when requested by regulatory or oversight organizations, including, but not limited to; DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

5. Medical Records. All medical records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1396a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Provider shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Participating Provider or Subcontractor site.

6. Downstream Contracts. In the event that Provider is allowed to subcontract for services under this Contract, and does so subcontract, then Provider shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Assignment and Delegation. This Contract is not assignable, nor are the duties hereunder delegable, by the Provider, either in whole or in part, without the prior written consent of CalOptima and DHCS, provided that consent may be withheld in their sole and absolute discretion. Any assignment or delegation shall be void unless prior written approval is obtained from both DHCS and CalOptima. For purposes of this Section and this Contract, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Provider; (iii) the merger, reorganization, or consolidation of Provider with another entity with respect to which Provider is not the surviving entity; and/or (iv) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

8. Third Party Tort Liability/Estate Recovery. Provider shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of a deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Provider shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

9. Records Related to Recovery for Litigation. Upon request by CalOptima, Provider shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Provider's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Provider or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

10. DHCS Policies. Covered Services provided under this Contract shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program and the DHCS Long-Term Care Division (LTCD).

11. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

12. Confidentiality of Medi-Cal Members. Provider and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Provider, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Provider and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Provider's obligations under this Contract. Provider and its employees, agents, or Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not

be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

12.1. Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Provider from unauthorized disclosure. Provider may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Provider is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider or its Subcontractors, Provider:

12.1.1. will not use any such information for any purpose other than carrying out the express terms of this Contract,

12.1.2. will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

12.1.3. will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

12.1.4. will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Provider by CalOptima for this purpose.

13. Debarment Certification. By signing this Contract, the Provider agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

13.1. By signing this Contract, the Provider certifies to the best of its knowledge and belief, that it and its principals:

13.1.1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

13.1.2. Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or

commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

13.1.3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Subprovision 13.1.2 herein; and

13.1.4. Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

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

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

13.2. If the Provider is unable to certify to any of the statements in this certification, the Provider shall submit an explanation to CalOptima.

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

13.4. If the Provider knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

14. DHCS Directions. If required by DHCS, Provider and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

15. Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions, unless said agreement is exempt under 40 CFR 15.5. Provider 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.

16. Lobbying Restrictions and Disclosure Certification.

16.1. (Applicable to federally funded contracts in excess of $100,000, per Section 1352 of the 31, U.S.C.)

16.2. Certification and Disclosure Requirements

16.2.1. Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and

which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1 to this Addendum 4, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 16.3 of this provision.

16.2.2. Each recipient shall file a disclosure (in the form set forth in Attachment 2 to Addendum 4, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 16.3 of this provision if paid for with appropriated funds.

16.2.3. Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure, or that materially affects the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 16.2.2 herein. An event that materially affects the accuracy of the information reported includes:

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

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

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

16.2.4. Each person (or recipient) who requests or receives from a person referred to in Paragraph 16.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

16.2.5. All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 16.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

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

extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

17. Provider shall have a right to submit an Appeal through the mechanisms set forth in CalOptima Policies regarding Provider dispute resolution.

Addendum 4--Attachment 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than #100,000 for each failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

Addendum 4--Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier, if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): c. cash b. in-kind, specify: Nature Value	13. Type of Payment (check all that apply): c. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:

18. 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:

19. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.
10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Actions Related to the Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service Hospital Contracts

Contact
Michelle Laughlin, Executive Director, Network Operations (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246 8400

Recommended Action(s)
Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service (FFS) Hospital Contracts through June 30, 2021, under the same terms and conditions.

Background/Discussion
CalOptima currently contracts with several hospitals to provide services to Medi-Cal, OneCare, OneCare Connect and PACE members. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the CalOptima Board of Directors.

Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS Hospital contracts, through June 30, 2021.

The renewal of these contracts with existing hospitals will support the stability of CalOptima's contracted FFS hospital network. Contract language does not guarantee any provider volume or exclusivity and allows for CalOptima and the providers to terminate the contracts with or without cause.

Fiscal Impact
The recommended action to extend CalOptima FFS hospital contracts through June 30, 2021, under the same terms and conditions, has no additional fiscal impact. To the extent there is any fiscal impact due to a unit cost change, such impact will be addressed in the CalOptima Fiscal Year 2020-21 Operating Budget or through separate Board actions to amend contracts.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the hospital network and to fulfill regulatory requirements.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
None

/s/ Michael Schrader *03/26/2020*
Authorized Signature **Date**

AMENDMENT II TO
HOSPITAL SERVICES CONTRACT

THIS AMENDMENT II TO THE AMENDED AND RESTATED HOSPITAL SERVICES CONTRACT ("Amendment II") is effective as of November 1, 2021, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and _____("Hospital"), with respect to the following facts:

RECITALS

A. CalOptima and Hospital have entered into a Hospital Services Contract ("Contract"), as amended, by which Hospital has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Hospital desire to amend this Contract on the terms and conditions set forth herein.

NOW, THEREFORE, the parties agree to the following amendments to the Contract:

1. Attachment A, "Hospital Services", shall be deleted in its entirety and replaced with the attached Attachment A – Amendment II, "Hospital Services".

2. Attachment B, "Compensation", is deleted in its entirety and replaced with the attached Attachment B – Amendment II, "Compensation".

3. Attachment B-1, "Medi-Cal Compensation Rates for Adult Expansion Members", is deleted in its entirety and replaced with the attached Attachment B-1 – Amendment II, "Medi-Cal Compensation Rates for Adult Expansion Members".

4. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract as previously amended shall continue in full force and effect. This Amendment II is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and Hospital have executed this Amendment II.

FOR HOSPITAL:	FOR CALOPTIMA:
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name
_____	Chief Operation Officer
Title	Title
_____	_____
Date	Date

ATTACHMENT A – AMENDMENT II

HOSPITAL SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 CalOptima Programs. Hospital shall furnish covered services to eligible members in the following CalOptima Programs:

___X__ Medi-Cal Program
___X__ OneCare Program
___X__ Cal MediConnect Program/OneCare Connect
___X___ PACE Program

ARTICLE 2
HOSPITAL SERVICES

2.1. Hospital is responsible for providing all covered Hospital Services, as authorized by CalOptima or the Member's shared risk physician group if applicable, provided that such services are available at Hospital, within Hospital's capacity and capability to provide, and Medically Necessary, including but not limited to:

1. Inpatient hospitalization for medical or surgical treatment in a ward or semi-private accommodation, unless a private room is Medically Necessary;
2. Hospitalization in an intensive care unit or special care unit;
3. Pediatric services;
4. Maternity services;
5. Psychiatric and substance abuse services;
6. Newborn nursery, all levels;
7. Ancillary services and supplies, including laboratory and radiology services;
8. Administration of outpatient prescription drugs (take home medications) in instances where continuation of hospital-based treatment shall not be interrupted: three (3) day supply minimum;
9. Emergency Department Services (as provided in Section 2.3 of this Contract, Emergency Services do not require prior authorization);
10. Outpatient services at Hospital's surgicenter or similar freestanding facility, or in Hospital's outpatient department(s); and
11. Administration of blood, blood plasma, or its derivatives, including cost of blood, blood plasma, or its derivatives.

ATTACHMENT B – AMENDMENT II

COMPENSATION RATES

For Covered Services provided to CalOptima Medi-Cal Members under this Contract, CalOptima shall reimburse Hospital, and Hospital shall accept as payment in full from CalOptima the lesser of billed charges or the following amounts:

I. Medi-Cal
(For Medi-Cal Expansion Members please see Attachment B-1)

Inpatient Services

Inpatient Services are payable under this contract at two different levels of service, as follows:

A. **Long Term Acute Care (LTAC) Level of Care**

Inpatient days are payable at the LTAC level of care for all days that are prior authorized at that level by CalOptima.

B. **Chronic/Maintenance Level of Care**

Inpatient days are payable at the Chronic/Maintenance level of care for all days prior authorized at that level by CalOptima, based on the following factors:

The member does not meet the LTAC criteria, but has the following medical requirements:

The Member needs:

- Tracheostomy care with continuous mechanical ventilation for at least 50 percent of the day; or
- Tracheostomy care with suctioning and room air mist or oxygen as needed, and one of the seven treatment procedures listed below; or
- Administration of any three of the seven treatment procedures listed below.

Treatment Procedures:

1. Hemodialysis or peritoneal dialysis
2. Total parenteral nutrition
3. Inpatient physical, occupational, and/or speech therapy, at least two hours per day, five days per week
4. Tube feeding (nasogastric or gastrostomy)
5. Inhalation therapy treatments every shift and a minimum of four times per 24-hour period
6. I.V. therapy involving:
   a. the continuous administration of a therapeutic agent, or
   b. the need for hydration, or
   c. frequent intermittent I.V. drug administration via a peripheral and/or central line (for example, with Heparin lock)
7. Debridement, packing and medicated irrigation with or without whirlpool treatment

Note: Excluding OneCare, OneCare Connect or PACE, for Members who are Medicare Part B as well as Medi-Cal, all Part B services are to be billed to fee-for-service Medicare.

Inpatient Rates

In accordance with the above designations, authorized services will be paid in accordance with the table below. No amounts are payable for any days for which prior authorization at one of the above levels of service has not been obtained.

Hospital Services	Revenue Codes	Per Diem Reimbursement
Inpatient Services – LTAC level of care	Refer to MediCal billing guidelines	$
Inpatient Services – Chronic/ maintenance level of care	Refer to MediCal billing guidelines	$

Other Services

Other Services	Revenue Codes	Per Diem Reimbursement
High Cost Exclusion Items	Refer to High Cost Exclusion Payment Policy	Refer to High Cost Exclusion Payment Policy

Excluded Items: Excluded items shall be reimbursed in accordance with CalOptima Policy.

Inpatient admissions to the hospital prior to the effective date of any rate amendment and where the Member is still inpatient on the date of this amendment, shall be paid at the rates in place at the time of admission for the entire length of the stay.

Billing and reimbursement will be in accordance with Medi-Cal payment guidelines.

Outpatient Services

- Outpatient services (excluding drugs) shall be reimbursed at 140% of Medi-Cal reimbursement rates.
- Outpatient administered drugs shall be reimbursed at 100% of Medi-Cal reimbursement rates.
- Outpatient services not contained in the Medi-Cal fee schedule at the time of services are not reimbursable.

Billing and reimbursement will be in accordance with Medi-Cal payment guidelines.

II. Medicare Advantage (OneCare)

Hospital Services	Revenue Codes	Per Diem Reimbursement
Inpatient Services – LTAC level of care	Refer to Medicare billing guidelines	$

Outpatient Services

- Outpatient services shall be reimbursed at 100% of Medicare Allowable Rates.

==========

Footnotes:

1. For Medicare Part A or Part B services provided to CalOptima Medicare Advantage Enrollee Patients, Hospital's compensation shall equal the applicable rate shown on this Attachment B.

2. Billing and reimbursement will be in accordance with Medicare payment guidelines.

3. All physician fees are excluded.

4. In the event of a contracted rate change, the rate in place at the time of admission is the rate that shall be paid.

III. Cal MediConnect (OneCare Connect)

Hospital Services	Revenue Codes	Per Diem Reimbursement
Inpatient Services – LTAC level of care	Refer to Medicare billing guidelines	$

Outpatient Services

- Outpatient services shall be reimbursed at 100% of Medicare Allowable Rates.

==========

Footnotes:

5. For Medicare Part A or Part B services provided to CalOptima Medicare Advantage Enrollee Patients, Hospital's compensation shall equal the applicable rate shown on this Attachment B.

6. Billing and reimbursement will be in accordance with Medicare payment guidelines.

7. All physician fees are excluded.

8. In the event of a contracted rate change, the rate in place at the time of admission is the rate that shall be paid.

IV. PACE

Hospital Services	Revenue Codes	Per Diem Reimbursement
Inpatient Services – LTAC level of care	Refer to Medicare billing guidelines	$

Outpatient Services

- Outpatient services shall be reimbursed at 100% of Medicare Allowable Rates.

==========

Footnotes:

9. For Medicare Part A or Part B services provided to CalOptima Medicare Advantage Enrollee Patients, Hospital's compensation shall equal the applicable rate shown on this Attachment B.

10. Billing and reimbursement will be in accordance with Medicare payment guidelines.

11. All physician fees are excluded.

12. In the event of a contracted rate change, the rate in place at the time of admission is the rate that shall be paid.

ATTACHMENT B-1 – AMENDMENT II

MEDI-CAL COMPENSATION RATES FOR ADULT EXPANSION MEMBERS

Inpatient Services

Inpatient Services are payable under this contract at two different levels of service, as follows:

A. **Long Term Acute Care (LTAC) Level of Care**

Inpatient days are payable at the LTAC level of care for all days that are prior authorized at that level by CalOptima.

B. **Chronic/Maintenance Level of Care**

Inpatient days are payable at the Chronic/Maintenance level of care for all days prior authorized at that level by CalOptima, based on the following factors:

The member does not meet the LTAC criteria, but has the following medical requirements:

The Member needs:

- Tracheostomy care with continuous mechanical ventilation for at least 50 percent of the day; or
- Tracheostomy care with suctioning and room air mist or oxygen as needed, and one of the seven treatment procedures listed below; or
- Administration of any three of the seven treatment procedures listed below.

Treatment Procedures:

8. Hemodialysis or peritoneal dialysis
9. Total parenteral nutrition
10. Inpatient physical, occupational, and/or speech therapy, at least two hours per day, five days per week
11. Tube feeding (nasogastric or gastrostomy)
12. Inhalation therapy treatments every shift and a minimum of four times per 24-hour period
13. I.V. therapy involving:
    a. the continuous administration of a therapeutic agent, or
    b. the need for hydration, or
    c. frequent intermittent I.V. drug administration via a peripheral and/or central line (for example, with Heparin lock)
14. Debridement, packing and medicated irrigation with or without whirlpool treatment

Note: Excluding OneCare, OneCare Connect or PACE, for Members who are Medicare Part B as well as Medi-Cal, all Part B services are to be billed to fee-for-service Medicare.

Compensation rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future payments to CalOptima, CalOptima will amend Contract to adjust payments made to Hospital.

For Covered Services provided to CalOptima Medi-Cal Adult Expansion Members under this Contract, CalOptima shall reimburse Hospital, and Hospital shall accept as payment in full from CalOptima the lesser of billed charges or the following amounts:

Inpatient Rates

In accordance with the above designations, authorized services will be paid in accordance with the table below. No amounts are payable for any days for which prior authorization at one of the above levels of service has not been obtained.

Hospital Services	Revenue Codes	Per Diem Reimbursement
Inpatient Services – LTAC level of care	Refer to MediCal billing guidelines	$
Inpatient Services – Chronic/ maintenance level of care	Refer to MediCal billing guidelines	$

Other Services

Other Services	Revenue Codes	Per Diem Reimbursement
High Cost Exclusion Items	Refer to High Cost Exclusion Payment Policy	Refer to High Cost Exclusion Payment Policy

Excluded Items: Excluded items shall be reimbursed in accordance with CalOptima Policy.

Inpatient admissions to the hospital prior to the effective date of any rate amendment and where the Member is still inpatient on the date of this amendment, shall be paid at the rates in place at the time of admission for the entire length of the stay.

Billing and reimbursement will be in accordance with Medi-Cal payment guidelines.

Outpatient Services

- Outpatient services (excluding drugs) shall be reimbursed at 140% of Medi-Cal reimbursement rates.
- Outpatient administered drugs shall be reimbursed at 100% of Medi-Cal reimbursement rates.
- Outpatient services not contained in the Medi-Cal fee schedule at the time of services are not reimbursable.

Billing and reimbursement will be in accordance with Medi-Cal payment guidelines.

Provider Advisory Committee Update
Board of Directors Meeting
November 4, 2021

On October 14, 2021, the Provider Advisory Committee (PAC) held its monthly meeting via teleconference using GoTo Meeting Webinar technology.

Yunkyung Kim, Chief Operating Officer, introduced herself to the committee and provided an update to the committee noting items of interest from the CEO Report to the Board for October.

Emily Fonda, M.D., Chief Medical Officer, provided a COVID-19 update to the PAC on the vaccine status in Orange County. She noted that 412,769 CalOptima members had been vaccinated and that 381,215 of those vaccinated were eligible for gift care incentives. Approximately 203,233 gift cards have been processed for CalOptima members and another 1,649 gift cards have been distributed to CalOptima members experiencing homelessness.

Nancy Huang, Chief Financial Officer, provided a quarterly financial update and reviewed the FY 2021-22 enrollment trend analysis and CalOptima's financial support of the ongoing COVID-19 pandemic. She discussed the upcoming Department of Healthcare Services (DHCS) incentive programs with the PAC, including CalAIM performance incentives and the student behavioral health incentive.

Sloane Petrillo, Director, Case Management, provided a homeless health update to the PAC. Jillian Youngerman, O.D. Assistant Professor, Ketchum University, presented on Back to School Learning Related Vision Disorders. Kristen Gericke, Director, Clinical Pharmacy, provided a Medi-Cal Rx update and Jackie Mark, Manager, Government Affairs, provided an update on items of interest on the Federal and State Legislative front.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the PAC's activities.

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Member Advisory Committee Update
Board of Directors Meeting
November 4, 2021

On October 14, 2021, the Member Advisory Committee (MAC) held its monthly meeting via teleconference using GoTo Meeting Webinar technology. The MAC at this meeting considered the recommendation of a Vice Chair due to the resignation from the committee of Pamela Pimentel, the Children Representative, who also held the Vice Chair seat. The committee after a roll-call vote recommended the appointment of Maura Byron, the Family Support Representative, to fulfill an existing term through June 30, 2022. MAC also said farewell to Patty Mouton, the Long-Term Services and Supports Representative, who resigned from the committee effective November 1, 2021.

Yunkyung Kim, Chief Operating Officer, introduced herself after being welcomed by MAC Chair Christine Tolbert. Ms. Kim provided the committee with a brief self-bio and reviewed items of interest from the October CEO Report to the Board.

Emily Fonda, M.D., Chief Medical Officer, provided a COVID-19 update to the MAC on the vaccine status in Orange County. Dr. Fonda noted that 412,769 CalOptima members had been vaccinated and that 381,215 of those vaccinated were eligible to receive gift card incentives. She noted that approximately 203,233 gift cards have been provided to CalOptima members and another 1,649 have been distributed to CalOptima members experiencing homelessness.

Sloane Petrillo, Director, Case Management, provided a homeless health update to the MAC and Kristen Gericke, Director, Clinical Pharmacy, provided a Medi-Cal Rx update. Rachel Selleck, Executive Director, Public Affairs, provided an update on Federal and State legislative items of interest to the MAC.

Christine Tolbert, MAC Chair, provided an update on current Health Care Task Force initiatives. The Health Care Task Force is a group of executive level administrators representing various stakeholders in Orange County that serve those with Intellectual and Developmental Disabilities (IDD) (e.g., Regional Center of Orange County, Community Legal Aid SoCal, CalOptima, Disability Rights California/Office of Clients' Rights Advocacy, Council on Aging, Help Me Grow, Family Resource Network, etc.) The group addresses trending systemic health-related issues affecting those with IDD and their families, and proposes effective policy/practice changes that are intended to improve services and foster communication amongst the involved agencies.

Once again, the MAC appreciates and thanks the CalOptima Board for the opportunity to provide updates on the MAC's activities.

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