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

SEPTEMBER 7, 2023
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

Clayton Corwin, Chair	Blair Contratto, Vice Chair
Debra Baetz	Isabel Becerra
Supervisor Doug Chaffee	Norma García Guillén
José Mayorga, M.D.	Supervisor Vicente Sarmiento
Trieu Tran, M.D.	Vacant

Supervisor Donald Wagner, Alternate

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

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

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

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

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
Participate via Zoom Webinar at:
https://us06web.zoom.us/webinar/register/WN_9z134VrNTSiBpcoSPE0LoQ and Join the Meeting.

Webinar ID: **879 4296 0561**

Passcode: **017378** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS
1. Chief Executive Officer Report

2. Update on Board-Designated Reserve Levels

3. CalAIM Workforce Development Program Results

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 August 3, 2023 Regular Meeting of the CalOptima Health Board of Directors

5. Approve Modifications to CalOptima Health Policy GA.3202: CalOptima Health Signature Authority

6. Approve New CalOptima Health Policy GG.1630: Reporting Communicable Diseases

7. Authorize and Direct Execution of a new "Companion Contract" with the California Department of Health Care Services for the CalOptima Health Program of All-Inclusive Care for the Elderly

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

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

REPORTS/DISCUSSION ITEMS
10. Election of Officers of the Board of Directors for Fiscal Year 2023-24

11. Approve Modifications to CalOptima Health Board-Designated Reserve Funds Policy

12. Approve Modifications to CalOptima Health Office of Compliance Policy: HH.3012: Non-Retaliation for Reporting Violations

13. Approve Contract for State and Local Advocacy Services

14. Ratify the Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Fee-for-Service Physicians, Except Physicians Employed by UCI Health or the University of California, Irvine, to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

15. Ratify a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Fee-for-Service Physicians Employed by UCI Health or the University of California, Irvine to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

16. Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2022

17. Approve Actions Related to Provision of Doula Services as a Covered Medi-Cal Benefit

18. Authorize Employee and Retiree Group Health Insurance and Wellness Benefits for Calendar Year 2024

19. Authorize Action Related to California Public Employees' Retirement System Unfunded Accrued Liability

20. Approve Actions Related to the Garden Grove Street Medicine Pilot Program and Support Center

ADVISORY COMMITTEE UPDATES

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

CLOSED SESSION

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

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

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors on September 7, 2023 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_9z134VrNTSiBpcoSPE0LoQ

To **Join** from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join.
https://us06web.zoom.us/s/87942960561?pwd=RXpJVXdXandZei94RWNBVHFnZTQ0dz09

Passcode: 017378

Or One tap mobile:
+16694449171,,87942960561#,,,,*017378# US
+17207072699,,87942960561#,,,,*017378# US (Denver)

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

Webinar ID: 879 4296 0561
Passcode: 017378

International numbers available: **https://us06web.zoom.us/u/k9BGsOap0**

MEMORANDUM

DATE:	August 30, 2023
TO:	CalOptima Health Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — September 7, 2023, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; and Whole-Child Model Family Advisory Committee

A. Medi-Cal Renewal Efforts Continue

CalOptima Health's approach to Medi-Cal renewal remains a top priority along with our colleagues at the County of Orange Social Services Agency (SSA). Here each department identifies its role to ensure eligible members retain their coverage. Below are highlights of recent activities and news related to renewals. In addition, because the renewal process is fluid and membership numbers fluctuate during the month, I will share further updates at the Board meeting on September 7.

- **Health Network Engagement**
  During CalOptima Health's August 17 Health Network Forum, COO Yunkyung Kim and Executive Director of Operations Ladan Khamseh shared detailed information about the data being transmitted to health networks for their use in supporting members' Medi-Cal renewals. We have asked all health networks to identify ways to engage their members to raise awareness about the renewal process, such as through telephone outreach or conversations at the point of care. Activating our health network partners is another strategy to support members' ongoing coverage.
- **Customer Service Calls**
  Our Customer Service staff continues outreach to members who have not returned their renewal packets. Nearly 6,400 Medi-Cal members with an August renewal month were engaged through inbound and outbound calls. For OneCare, 250 members were engaged.
- **Community Events**
  On Saturday, August 26, more than 3,000 community members attended our inaugural Back-to-School Health and Wellness Event in Anaheim. The event offered an opportunity to highlight the importance of Medi-Cal renewal as well as provide resources for children, including the on-site vision and dental screenings and distribution of food, diapers, bike helmets and backpacks.
- **Texting Campaigns**
  In August, CalOptima Health intensified our texting campaigns to reach members in support of the renewal process. Since the start, more than 148,000 text messages (in threshold languages) have been sent to members with renewal months from June to November. There are two types of messages: one reminds members to return their renewal packets and the other urges members to update their contact information using an interactive app. To date, more than 17,200 addresses have been confirmed as correct, and 1,605 members provided updated contact information, which was

sent to the County of Orange Social Services Agency (SSA). A new text campaign will begin in early September to reach members whose coverage was terminated, encouraging them to take action to be reinstated during the 90-day window when there will be no gap in coverage.

- **State Medi-Cal Dashboard**
  On August 7, the Department of Health Care Services (DHCS) introduced a new interactive Medi-Cal dashboard detailing statewide and county-level demographic data on Medi-Cal application processing, enrollments, redeterminations and renewal outcomes. DHCS will update and adjust the dashboard monthly throughout the remainder of the year-long redetermination process.

B. CalOptima Health's Street Medicine Program Enjoys Success With Plans to Grow

Our street medicine program has made significant strides in providing health care and social services to the unhoused population of Garden Grove. Since April, Healthcare in Action has interacted with 201 individuals and now 92 participants are enrolled in Enhanced Care Management (ECM) — a CalAIM-funded state benefit. Furthermore, CalOptima Health planning to bring the topic of program expansion to a future Board meeting. Officials from other cities have expressed interest in having the program for their areas. Most recently, the City of Santa Ana unanimously supported submitting a letter of interest to CalOptima Health about the program. The letter stated that our program will complement and enhance Santa Ana's outreach and engagement services for people experiencing.

C. Media Event Highlights $2 Million Check for Care Traffic Control Command Center

CalOptima Health hosted a media event on August 15 to amplify the successful efforts of U.S. Representatives Lou Correa and Young Kim to award $2 million to support our Care Traffic Control Command Center. This marked the first time that CalOptima Health has received federal earmark funds. The media event featured remarks by COO Yunkyung Kim and Reps Correa and Kim, a check presentation, and a tour of the future Care Traffic Control Command Center located on the third floor of the 500 Building. KABC ran this piece during the 4 p.m. newscast.

D. DHCS Releases First Report on CalAIM Services

On August 3, DHCS released a report highlighting a notable increase in the number of Californians using the wide array of CalAIM benefits, including Enhanced Care Management (ECM) and Community Supports, in the first year since the January 2022 launch. Statewide, more than half of Medi-Cal members enrolled in ECM in 2022 were individuals who were at risk of avoidable hospital or emergency department visits, more than 42,000 were members with serious mental health/substance use disorder needs, and more than 36,000 members were individuals experiencing homelessness. DHCS expects even more Californians to use these expanded Medi-Cal services in 2023 and 2024 as eligibility includes new populations of focus, and as more providers contract with Medi-Cal managed care plans. In the report, CalOptima Health ranked near the top in delivery of Community Supports. Specifically:

- **We have the second-highest number of services provided in the state.**
- **We have the fifth-highest utilization rate in the state.**

It should be noted that this report includes data as of December 31, 2022. Our utilization has skyrocketed since then, so 2023 should show more impressive results. Further, our ECM Academy that trains providers graduated its first cohort in July, and we expect that ECM utilization will increase.

E. CalOptima Health to Host CalAIM Conference

CalOptima Health's CalAIM team has developed a two-day conference to foster deeper collaboration among managed care plan peers leading CalAIM implementation. CalAIM Implementation Share & Learn will be held October 3–4 at the Avenue of the Arts Hotel in Costa Mesa. The in-person

conference will encourage attendees from managed care plans, ECM providers and CBOs to work together to build stronger relationships and share successes and roadblocks.

F. Funding Opportunity for Organizations Serving Unhoused Members to Close Soon

With the Board's support of the ongoing Housing and Homelessness Incentive Program (HHIP), CalOptima Health released a Nonprofit Healthcare Academy Notice of Funding Opportunity (NOFO) to help build the capacity of smaller, grassroots community-based organizations (CBOs) serving populations experiencing health disparities. In its initial phase, CalOptima Health will identify and onboard up to 20 CBOs with operating budgets of $5 million or less. The NOFO is available through this portal, and applications are due by September 15, 2023, at 5 p.m.

G. Incentive Payment Program (IPP) Grant Awards Fuel Success Through Community Supports

At the heart of CalAIM is collaboration with organizations rooted in the community, and CalOptima Health is making community investments to build those connections and increase regional capacity. Since CalAIM launched in January 2022, CalOptima Health has drawn down significant dollars from DHCS through the related Incentive Payment Program (IPP). Initial funds were dispersed to our first Community Supports providers and participating health networks who were operating as our initial Enhanced Care Management (ECM) providers. As this program evolved, CalOptima Health has turned to these funds to build the capacity of new Community Supports providers and for community health centers and community-based organizations to onboard as ECM providers. Altogether, 42 grant awards provided a total of $4.2 million of community investment. CalOptima Health anticipates making additional funding opportunities to further develop these new benefits, offering culturally relevant services to populations of focus, and ensuring providers are accessible in all parts of the county where our members reside.

H. "Pulse for Good" Experience Feedback Program Launching Soon

Through a partnership with Pulse for Good, CalOptima Health is launching a program that will help providers obtain feedback on their services from members experiencing homelessness. Offered to CalOptima Health's housing navigation providers, Pulse for Good empowers them with insights directly from the people frequenting their sites and using their services. Currently, 11 housing navigation providers are participating in the program and 18 standalone kiosks will be installed at their combined 18 unique locations throughout the county. They will also receive start-up funding to support the integration of this technology into their organization's operations and evaluation processes.

I. Three New Medical Leaders Join CalOptima Health

- **Natalie Do, Pharm.D., D.O., Medical Director, Behavioral Health**
  Dr. Do is a double board-certified psychiatrist specializing in child and adolescent psychiatry. She attended pharmacy school at the University of Southern California, and she conducted HIV/AIDS research in Botswana as a Fulbright Scholar with the Botswana/Harvard AIDS Partnership. She practiced inpatient pharmacy while completing her medical education at Western University of Health Sciences. She completed her Adult/General Psychiatry residency at Loma Linda University and continued her training in psychiatry at UC San Diego in the Child and Adolescent Psychiatry program.
- **Robin Hatam, D.O., Medical Director, Chronic and End-Stage Kidney Disease**
  Dr. Hatam will lead CalOptima Health's efforts to improve care for members with chronic and end-stage kidney disease. He will also support CalOptima Health's network and hospital relations. He is a board-certified internist with experience working for prominent Medi-Cal and Medicare Advantage organizations. Dr. Hatam holds a bachelor's degree in Molecular and Cell Biology from

UC Berkeley, and a Doctor of Osteopathic Medicine degree from Western University of Health Sciences. He did his residency training in internal medicine at LAC+USC Medical Center.

- **Claus Hecht, M.D., Street Medicine Medical Director**
  Dr. Hecht is an emergency medicine specialist. He joins CalOptima Health in a new medical director position focused on serving those in our street medicine program. Dr. Hecht was most recently the medical director at the Orange County Fire Authority, a position he held since 2017. Prior to that, he served in emergency rooms across Southern California, including Corona Regional Medical Center, West Anaheim Medical Center, Western Medical Center Santa Ana and Eisenhower Medical Center. He has more than 24 years of experience in the medical field. He received a bachelor's degree from UC Irvine and his medical degree from Saint Louis University School of Medicine.

J. Recruitment Underway for Board Member Representative

Nancy Shivers, the CalOptima Health director representing members, resigned from the Board of Directors effective August 3. An application for this position can be found on the Orange County Health Care Agency website.

K. CalOptima Health Gains Media Coverage

CalOptima Health continues to receive positive and valuable media coverage.

- On August 7, the Orange County Register featured a quote from Carmen Katsarov, Executive Director of Behavioral Health Integration, on the collaboration between CalOptima Health and the Orange County Department of Education with a $25.5 million investment in schools through the Student Behavioral Health Incentive Program (SBHIP).
- On August 8, KNX radio interviewed Natalie Zavala, Director of Behavioral Health Integration, on the impact of SBHIP in Orange County Schools starting this fall.

CalOptima Health

Fast Facts
September 2023

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

Membership Data* (as of July 31, 2023)

Total CalOptima Health Membership

979,618

Program	Members
Medi-Cal	961,494
OneCare (HMO D-SNP)	17,695
Program of All-Inclusive Care for the Elderly (PACE)	429

*Based on unaudited financial report and includes prior period adjustment

Operating Budget (for one month ended July 31, 2023)

	YTD Actual	YTD Budget	Difference
Revenues	$362,777,779	$362,111,870	$665,909
Medical Expenses	$318,962,339	$336,362,133	$17,399,794
Administrative Expenses	$16,784,946	$20,011,467	$3,226,521
Operating Margin	$27,030,494	$5,738,270	$21,292,224
Medical Loss Ratio (MLR)	87.9%	92.9%	(5.0%)
Administrative Loss Ratio (ALR)	4.6%	5.5%	0.9%

Reserve Summary (as of July 31, 2023)

	Amount (in millions)
Board Designated Reserves	$579.0*
Capital Assets (Net of depreciation)	$83.9
Resources Committed by the Board	$650.4
Resources Unallocated/Unassigned	$397.0*
Total Net Assets	$1,710.3

Total of Board designated reserves and unallocated resources can support approximately 90 days of CalOptima Health's current operations.

Total Annual Budgeted Revenue **$4 Billion**

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

CalOptima Health Fast Facts

September 2023

Personnel Summary (as of August 12, 2023, pay period)

	Filled	Open	Vacancy %
Staff	1,314.3	79.1	5.68%
Supervisor	79.0	5.0	5.95%
Manager	116.0	8.0	6.45%
Director	56.5	7.5	11.72%
Executive	21	1	4.55%
Total FTE Count	1,586.8	100.6	5.96%

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

Provider Network Data (as of July 31, 2023)

	Number of Providers
Primary Care Providers	1,292
Specialists	8,651
Pharmacies	560
Acute and Rehab Hospitals	43
Community Health Centers	52
Long-Term Care Facilities	104

Treatment Authorizations (as of June 30, 2023)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	18.68 hours
Prior Authorization – Urgent	72 hours	17.24 hours
Prior Authorization – Routine	5 days	1.84 days

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

Member Demographics (as of July 31, 2023)

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

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

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

Back to Agenda

CalOptima Health

$50 million Workforce Development Plan Update

Our Mission

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

Our Vision

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

Back to Agenda

Goal of the Grant Initiative

- **Goal: Close gaps in the health care workforce in Orange County to increase access to high-quality, equitable care for CalOptima Health members.**
  - As Orange County's population ages and becomes increasingly diverse, our health delivery system needs to anticipate ongoing and future workforce needs
  - The pandemic magnified gaps in access to care and the impacts of social determinants of health as well as placed unprecedented personal and financial demands on health care workers. Filling these gaps will be vital in the support of population health.
  - Disparities in access to and quality of care are further exacerbated by a lack of diversity and language concordance in the health care workforce
  - The cost of living and other economic factors in Orange County challenge the workforce to remain here to serve our members. Many health care workers have left the workforce, and new workers are needed.
  - This grant initiative is intended to assist in filling these gaps by providing economic assistance to address critical workforce shortages

Source: California Future Health Workforce Commission

Back to Agenda

CalOptima Health

Existing Workforce and Access Investments

CalOptima Health has already launched four significant health care workforce investment programs.

1. **Coalition of Orange County Community Health Centers**
   - $50 million investment over five years focused on population health and value-based care transformation, including workforce investments
2. **CSU Fullerton – Master of Social Work Program**
   - $5 million over five years for select CSU Fullerton social work students to receive stipends of $20,000 per academic year
   - Ties participation to serving Orange County at the completion of the program
3. **National Alliance for Mental Illness (NAMI) Orange County**
   - $5 million grant partnership with NAMI to expand access to peer support services for Medi-Cal members
4. **Chrysalis Orange County**
   - $2.9M grant partnership to increase capacity of the Orange County homeless continuum of care by creating 130 jobs for unhoused and justice-involved individuals

Back to Agenda

CalOptima Health

Priorities for Five-Year Workforce Development Plan

- The health care workforce challenges before us are significant based on data on workforce shortages, gaps in access to care, and long wait times for services. A focused approach will maximize the impact of the $50 million investment.
- As a Medi-Cal managed care plan, CalOptima Health will work to address health equity and the unique needs of the Medi-Cal member population in prioritizing our investment in health care workforce development
- We will achieve this vision by prioritizing investment in the following ways:
  - **Identify and address shortages and gaps in the Orange County health care workforce that serves the Medi-Cal population, including physicians;**
  - **Aim to increase the diversity of the healthcare workforce; and**
  - **Provide economic support to allow individuals to pursue a career in health care in service to CalOptima Health members in Orange County**
- *NOTE: Any CalOptima Health investments will avoid supplanting or replacing existing federal and state funding sources for workforce development initiatives.*

Back to Agenda

CalOptima Health

Recommended Workforce Investments

- Based on a review of local needs and stakeholder engagement, CalOptima Health aims to fund initiatives in the following three focus areas:

1. **College/University-based educational investments** that increase the 'pipeline' of students moving into the health care workforce based on identified gaps in caregivers;
2. **Investments for training and certification programs** to address shortages of mid-level providers; and
3. **Targeted physician recruitment investment** to address identified Medi-Cal access gaps in primary and specialty care

Back to Agenda

Recommended Specific Grant Investments

- Based on a review of our member customer service records, network data, and member grievances, along with input from our health networks (including acute care providers) and community clinics, it is recommended that workforce development investments address shortages that specifically impact the Medi-Cal population
- Specific Grant Recommendations:
  - **Behavioral Health Providers (Individual Therapists for Children and Adults)**
  - **Nurses (Ambulatory Care and Acute Care)**
  - **Primary and Specialty Care**
  - **Ancillary Providers (TBD)**

NOTE: This list will be further validated through stakeholder engagement, available market workforce studies, and internal data analytics.

Back to Agenda

CalOptima Health

Stakeholder Engagement Process

- CalOptima Health has already begun engaging with our Joint Member and Provider Advisory Committee, our health network and provider partners, and institutions of higher education to identify workforce shortages and opportunities for grant investments.
- A robust stakeholder engagement process will continue in September and will include but will not be limited to:
  - Institutions of higher education, including the University of California, Irvine, all Orange County colleges, community colleges, Unified School Districts for high school medical magnet programs
  - County agencies
  - Coalition of Orange County Community Health Centers, clinics
  - Hospitals, health systems, medical groups, contracted networks, skilled nursing facilities

Back to Agenda

Stakeholder Engagement Process (cont.)

- State agencies/offices, including California Department of Healthcare Access and Information and the Governor's Office of Business and Economic Development
- Orange County Business Council
- OC Workforce Development Board
- CEO Leadership Alliance of Orange County
- Orange County Hispanic Chamber of Commerce
- Orange Workforce Alliance
- Orange County Labor Federation
- Other economic development organizations in Orange County

Back to Agenda

CalOptima Health

Grant Application and Review Process

- CalOptima Health will utilize its existing grant proposal evaluation process to select awardees
- The first funding round will be awarded in Q4 of 2023 and will make available ~$10m in grants
- A second round of funding will be awarded in Q1 of 2024 and will make available ~$10m in grants

NOTE: Grant funding will be allocated over a 3-5-year time period.

Back to Agenda

CalOptima Health

Memo

To: CalOptima Health Board of Directors

From: Nancy Huang, Chief Financial Officer

CC: Michael Hunn, Chief Executive Officer

Date: August 28, 2023

Re: Update on Board-designated Reserve Levels

At the June 1, 2023, meeting, the Board discussed the CalOptima Health reserve policy and requested staff to provide additional information once the following outstanding items were finalized: (1) Federal debt ceiling legislation; (2) Fiscal Year (FY) 2023-24 State Budget; and (3) California Department of Health Care Services (DHCS) 2024 Contract Financial Performance Guarantee requirement.

1. Federal debt ceiling legislation: On June 3, 2023, President Biden signed *H.R. 3746: Fiscal Responsibility Act of 2023* to avert the debt ceiling crisis. The legislation suspended the federal debt limit through January 1, 2025, and set discretionary spending caps for federal FYs 2024 and 2025 and appropriations targets for federal FYs 2026 through 2029.

2. FY 2023–24 State Budget: On June 27, 2023, Governor Newsom and the State Legislature finalized the FY 2023–24 state budget package totaling $310.8 billion, including $225.9 billion from the state's General Fund (GF). The budget closes a projected $31.7 billion budget shortfall through funding shifts, reductions or pullbacks of previously approved spending, delayed spending, new revenue proposals and internal borrowing, and trigger reductions.

   The budget included $37.5 billion in GF spending for the Medi-Cal program. The enacted budget builds on previous investments, including CalAIM, and largely protects safety net funding through June 30, 2024.

3. DHCS financial performance guarantee: On July 21, 2023, DHCS provided information related to the financial performance guarantee requirement in the new Medi-Cal managed care plan contract for January 1, 2024. Instead of making two month's of contract revenue a mandatory requirement, DHCS will require managed care plans to maintain a financial performance guarantee of at least one month's contract revenues. At its discretion, DHCS may increase the required amount to two months' contract revenues for any material breach of contract.

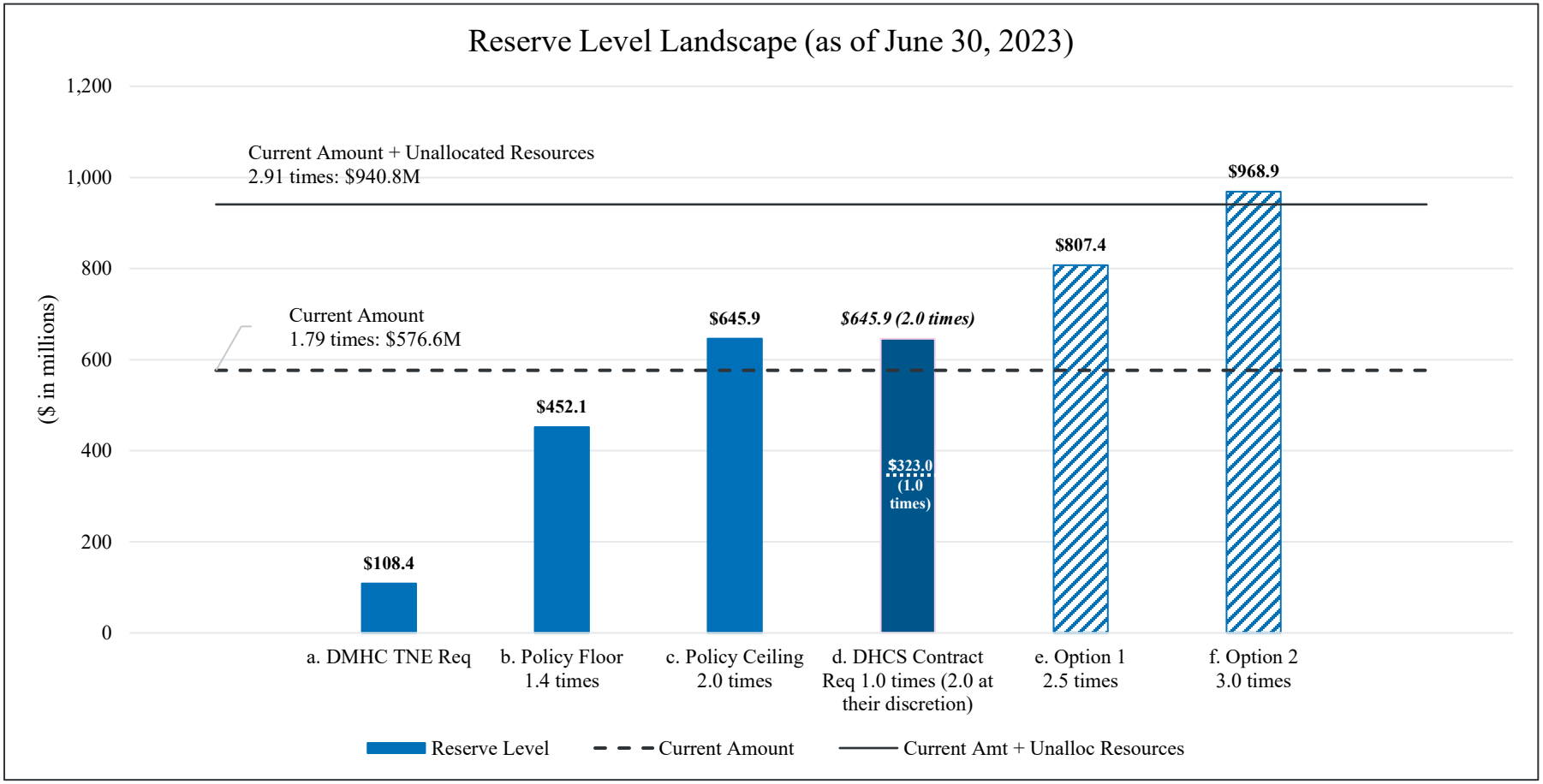
However, the new Medi-Cal managed care contract will include additional obligations related to community reinvestment and quality achievement. Specifically, the contract requires plans to submit a Community Reinvestment Plan to DHCS for approval. CalOptima Health would be required to contribute approximately 5% to 6% of our annual net income[1] to community reinvestment activities. In addition, if quality outcome measures are not met, DHCS would require CalOptima Health to contribute an additional 7.5% of its annual net income to community reinvestment. Staff is currently reviewing the fiscal and operational impacts of these contract provisions and will return to the Board with further recommendations.

Staff Recommendation

Based on the updated information, staff recommends keeping the current range of Board-designated reserve level unchanged at 1.4 months to 2.0 months of CalOptima Health's consolidated capitation revenues in Policy GA.3001: Board-Designated Reserve Funds.

However, staff will bring recommended policy changes for the Board's consideration at the September meeting. These changes clarify the Board's governance over total net assets and a review process of reserve levels.

[1] Set percentage defined as (a) 5% of the portion of annual net income that is ≤ 7.5% of contract revenues for the year and (b) 7.5% of the portion of annual net income that is > 7.5% of contract revenues for the year.


Reserve Level Landscape (as of June 30, 2023)
1,200
1,000
800
600
400
200
0
($ in millions)
Current Amount + Unallocated Resources
2.91 times: $940.8M
Current Amount
1.79 times: $576.6M
$108.4
$452.1
$645.9
$645.9 (2.0 times)
$323.0 (1.0 times)
$807.4
$968.9
a. DMHC TNE Req
b. Policy Floor 1.4 times
c. Policy Ceiling 2.0 times
d. DHCS Contract Req 1.0 times (2.0 at their discretion)
e. Option 1 2.5 times
f. Option 2 3.0 times
Reserve Level
Current Amount
Current Amt + Unalloc Resources

MANAGEMENT REPORTS

3. CalAIM Workforce Development Program Results – Verbal Update

Back to Agenda

MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

August 3, 2023

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on August 3, 2023, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. Chair Corwin called the meeting to order at 2:03 p.m., welcomed Debra Baetz as CalOptima Health's newest Board member, and asked Director Baetz to lead the Board in the Pledge of Allegiance.

ROLL CALL

Members Present: Clayton Corwin, Chair; Debra Baetz (non-voting); Isabel Becerra; Supervisor Doug Chaffee; Norma García Guillén; Jose Mayorga, M.D.; Supervisor Vicente Sarmiento; Trieu Tran, M.D.

(All Board members in attendance participated in person except Director García Guillén, who participated remotely under Just Cause, using her first use under Just Cause as permitted by AB 2449)

Members Absent: Blair Contratto, Vice Chair; Nancy Shivers

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

PRESENTATIONS/INTRODUCTIONS

None.

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

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Yunkyung Kim, Chief Operating Officer (COO), presented the Chief Executive Officer's report and started by welcoming Director Baetz to the CalOptima Health Board and to the mission of CalOptima Health.

Ms. Kim reviewed the Fast Facts data, noting that currently CalOptima Health serves 988,716 individuals with membership continuing to increase monthly. CalOptima Health spends 92.6% of every dollar on medical care, and 4.5% is the overhead cost to administer the program.

CalOptima Health's Board-designated reserves are $576.6 million; its capital assets are $84.2 million; its resources committed by the Board are $654.4 million; and its unallocated and unassigned resources are $364.2 million. Ms. Kim noted that CalOptima Health's total net assets are currently $1.6 billion.

Ms. Kim also reviewed the CalOptima Health personnel data and noted that there are about 1,500

employees with a vacancy/turnover rate of about 6.36% as of the July 1, 2023, pay period. CalOptima Health's vacancy/turnover target is to be at less than 12.5% to 15% at any given time.

Ms. Kim reviewed the provider data, noting that CalOptima Health has over 9,600 providers, 1,288 primary care providers, and 8,374 specialists; 563 pharmacies; 43 acute and rehab hospitals; 34 community health centers; and 103 long term care facilities.

Ms. Kim reviewed CalOptima Health's treatment authorizations, noting that this data is as of May 31, 2023. For urgent inpatient treatment authorizations, the average approval is within 9.81 hours; the state-mandated response is 72 hours. For urgent prior authorizations, the average approval is within 13.28 hours; the state-mandated response is 72 hours. And for routine prior authorizations, the average approval is 1.76 days; the state-mandated response is 5 days.

Ms. Kim updated the Board on CalOptima Health's Medi-Cal redetermination efforts, including its texting campaign. She noted that CalOptima Health continues to work closely with the Social Services Agency (SSA) to educate members on the importance of responding to the mailing regarding redetermination to ensure members continue to have health care coverage. She also noted that about $1/12^{th}$ of CalOptima Health's membership would be affected by the redetermination each month.

Ms. Kim added that Chief Executive Officer, Michael Hunn, and SSA Director, An Tran, have been visiting various cities in Orange County to spread the word about redetermination for Medi-Cal members. She noted that there is a 90-day grace period for rejoining CalOptima Health if members lose coverage due to redetermination.

Ms. Kim also mentioned that community outreach events have been a huge success. One example is the outreach event held on July 29, 2023, which was collaborative of various entities, including SSA, Supervisor Sarmiento's office and others, which was attended by over 4,200 individuals. CalOptima Health will continue to participate in these events to educate people on the benefits available.

Director Becerra commended staff on the proactive approach to ensure that members do not lose health coverage as a result of the Medi-Cal redetermination. Director Becerra noted that Ms. Kim had reported that 8,000 members lost coverage in June and asked about the average disenrollment. Ms. Kim responded that the average disenrollment is about 5,000 a month.

Ms. Kim responded to the Board's questions regarding the texting campaign and outreach to providers that see large numbers of members for assistance in ensuring members continue receiving healthcare coverage.

Supervisor Sarmiento thanked Ms. Kim for the presentation and CalOptima Health's help last Saturday at the community event. He noted that his staff hoped that the event would hit the same threshold as the last event held in Santa Ana of about 1,500 individuals and they were surprised to see about 4,200 individuals. Supervisor Sarmiento added that even in the heat with that many people coming out tells us there is a need for people to receive information and services.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

2. Minutes

a. Approve Minutes of the June 1, 2023 Regular Meeting of the CalOptima Health Board of Directors and the Minutes of the June 29, 2023 Special Meeting of the CalOptima Health Board of Directors
b. Receive and File Minutes of the March 15, 2023 Special Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

3. Approve New CalOptima Health Policy GG.1661: External Quality Review Requirements

4. Approve the 2022 CalOptima Health Utilization Management Program Evaluation and the 2023 CalOptima Health Integrated Utilization Management/Case Management Program Description

5. Ratify a Contract Amendment Related to Local Advocacy Services

Supervisor Sarmiento did not participate in this item due to conflicts of interest under the Levine Act.

6. Appointments to the CalOptima Health Whole-Child Model Family Advisory Committee

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

8. Appointments to the CalOptima Health Board of Directors' Provider Advisory Committee

9. Receive and File:

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

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 2 through 9, minus Agenda Item 5 as presented. (Motion carried 7-0-0; Vice Chair Contratto and Director Shivers absent)***

5. Ratify a Contract Amendment Related to Local Advocacy Services

Supervisor Sarmiento did not participate in this item due to conflicts of interest under the Levine Act.

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors ratified an amendment to retroactively extend the contract with Whittingham Public Affairs Advisors (WPAA) for local advocacy services from June 3, 2023, through June 30, 2023. (Motion carried 6-0-0; Supervisor Sarmiento recused; Vice Chair Contratto and Director Shivers absent)***

REPORTS/DISCUSSION ITEMS

10. Extend the Terms of the Current Chair and Vice Chair of the Board of Directors until the September 2023 Board Meeting

Director Becerra asked staff to work with Outside General Counsel on outlining procedures regarding the annual election of the Chair and Vice Chair of the CalOptima Health Board.

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors extended the Terms of the Current Chair and Vice Chair of the Board of Directors (Board) until the September 2023 Board Meeting. (Motion carried; 7-0-0; Vice Chair Contratto and Director Shivers absent)***

11. Authorize Naloxone Distribution Event for CalOptima Health Members

Ms. Kim introduced the item, noting the staff is asking the Board to approve the purchase and distribution of up 250,000 doses of Naloxone to its members in an effort to promote public safety and address potential access and accessibility issues to life-saving medication. She noted that the opioid epidemic has been a public health emergency since 2017 and the community has continued to see overdose deaths increase year over year. Many overdose deaths can be prevented with Naloxone, which people may know under the brand name Narcan. CalOptima Health believes that Naloxone can be a first aid response tool for families and individuals for life-threatening opioid overdoses, the same way that Epi-pens are now broadly available tools for life threatening allergic reactions.

Richard Pitts, D.O., Ph.D., Chief Medical Officer, noted for the Board and the public that it is most important to also activate 911 when administering Naloxone. He also noted that Fentanyl is 100 times stronger than morphine and heroin. Dr. Pitts added that now on the streets there is something called Car Fentanyl, which is 10,000 times stronger that morphine. Substance abuse needs to be looked at as medical condition, which it is.

Board members were very supportive of this effort and after considerable discussion the Board took the following action:

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors: 1.) Authorized CalOptima Health to host an event to distribute naloxone to members; 2.) Authorized the allocation and expenditure of up to $15 million from existing reserves to fund the purchase of naloxone doses for members, and to organize, promote and execute the event and distribution of unused doses; 3.) Authorized the Chief Executive Officer to engage partners and execute contracts to implement the event; and 4.) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose. (Motion carried; 7-0-0; Vice Chair Contratto and Director Shivers absent)***

12. Approve Actions Related to the Housing and Homelessness Incentive Program for the Nonprofit Healthcare Academy

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer to execute a one (1)-year contract with Consilience Group, LLC, effective September 1, 2023, with a one (1) year renewal option at CalOptima Health's discretion to provide Nonprofit Healthcare Academy technical services; and 2.) Authorized CalOptima Health staff to conduct a notice of funding opportunity (NOFO) process related to the Nonprofit Healthcare Academy, administer grant agreements and release award payments to up to 20 selected community-based organizations in an amount up to $5,000 per grantee. (Motion carried; 7-0-0; Vice Chair Contratto and Director Shivers absent)***

13. Ratify the Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Fee-for-Service Physicians, Except Physicians Employed by UCI Health or the University of California, Irvine, to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency
This item was continued due to a lack of a quorum.

14. Ratify a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Fee-for-Service Physicians Employed by UCI Health or the University of California, Irvine to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency
This item was continued due to a lack of a quorum.

15. Authorize Contract with a Non-Medical Transportation and a Non-Emergency Medical Transportation Vendor Effective January 1, 2024
Supervisor Sarmiento asked how many bidders responded to the request for proposal, and Ms. Kim responded that there were five responses received. Supervisor Sarmiento inquired why CalOptima Health would change from the incumbent to the proposed vendor, and Ms. Kim responded that the incumbent did not currently have the capacity to provide Non-Emergency Medical Services (NEMT) for CalOptima Health's members.

Supervisor Sarmiento noted that it would be helpful to have additional detail such as the criteria and weighting for RFPs in the future.

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors authorized the Chief Executive Officer to: 1.) Execute a contract with ModivCare Solutions, LLC (ModivCare) to serve as CalOptima Health's Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) vendor for OneCare and Medi-Cal members. The contract is to be effective April 1, 2024, for a three (3) year term with two (2) additional one-year extension options, each exercisable at CalOptima Health's sole discretion; and 2.) Extend the current contract with Medical Transportation Management Inc. (MTM) for 90 days to provide NMT services for OneCare and Medi-Cal members. Contract to be effective January 1, 2024, through March 31, 2024. (Motion carried 7-0-0; Vice Chair Contratto and Director Shivers absent)***

16. Authorize an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc., to extend the Contract

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO) to execute an amendment to extend the current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for the OneCare and PACE lines of business for two years, effective January 1, 2025 to December 31, 2026. (Motion carried 7-0-0; Vice Chair Contratto and Director Shivers absent)***

ADVISORY COMMITTEE UPDATES

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

Jena Jensen, Chair of the Provider Advisory Committee (PAC) updated the Board on recent activities at the Joint Meetings of the Member Advisory Committee (MAC) and the PAC. Ms. Jensen noted that their next meeting will be held on August 10, 2023.

CLOSED SESSION

The Board adjourned to Closed Session at 3:04 p.m. pursuant to Government Code Section 54956.8, CONFERENCE WITH REAL PROPERTY NEGOTIATORS, Under Negotiation: Price and terms of payments, Property: 7900 Garden Grove Avenue, Garden Grove, CA 92841, Agency Negotiators: David Kluth, and Mai Hu, Newmark Knight Frank, Negotiating Parties: Lvt, Inc. and pursuant to Government Code Section 54957(b)(1), PUBLIC EMPLOYEE PERFORMANCE EVALUTION, [Chief Executive Officer].

The Board returned to open session at 3:59 p.m. with no reportable actions taken.

ADJOURNMENT

Hearing no further business, Chair Corwin adjourned the meeting at 4:00 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: September 7, 2023

CalOptima Health Board Action Agenda Referral

Action To Be Taken September 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

5. Approve Modifications to CalOptima Health Policy GA.3202: CalOptima Health Signature Authority

Contacts

Nancy Huang, Chief Financial Officer, (657) 235-6935
John Tanner, Chief Compliance Officer, (657) 235-6997

Recommended Action

Approve modifications to CalOptima Health Policy GA.3202: CalOptima Health Signature Authority.

Background

At the August 4, 2022, meeting the Board of Directors (Board) approved modifications to CalOptima Health Policy GA.3202: CalOptima Health Signature Authority. Among other changes, the policy was modified to delegate authority to the Chief Executive Officer (CEO) to approve CalOptima Health policies that only contain non-substantive changes or changes made to comply with law. The CEO would obtain legal advice in determining the nature of changes in policies and procedures.

Discussion

Staff requests that the Board approve modifications to the policy as follows:

Section	Proposed Change	Rationale
III.C.2.a. and b.	Specify that the CalOptima Health policies and procedures that the CEO is authorized to sign without Board approval are those that (1) contain non-substantive changes or (2) substantive changes in compliance with contractual requirements subject to legal review and concurrence.	Clarify CEO authorization of policy and procedure approvals.

Fiscal Impact

There is no fiscal impact.

Rationale for Recommendation

This policy update will enhance the efficiency of CalOptima Health's operations and governance.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Back to Agenda

Attachments

1. CalOptima Health Policy GA.3202: CalOptima Health Signature Authority

/s/ Michael Hunn *08/31/2023*
Authorized Signature **Date**

Back to Agenda

Policy:	GA.3202
Title:	**CalOptima Health Signature Authority**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	03/01/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy sets forth the requirements for the execution of any document binding CalOptima Health in any manner.

II. POLICY

A. A CalOptima Health officer or employee may not expend any funds or take any other action on behalf of CalOptima Health, unless the Board of Directors (Board) has approved such expenditure or action, or delegated its power to that officer or employee, subject to an articulated standard.

B. No document of any type whatsoever that binds CalOptima Health to undertake or refrain from undertaking any action, or to expend any CalOptima Health funds, shall be entered into except pursuant to this Policy.

C. In order for any document to bind CalOptima Health, the Board of Directors must have: (1) appropriated funds for the purpose identified in that document, (2) authorized the subject matter of the underlying action, and (3) the document must be executed by an authorized CalOptima Health representative, as identified in this Policy.

D. Amendments or other changes to any document binding CalOptima Health must be approved and executed in the same manner as the original document, except for minor price deviations, as provided within this Policy.

III. PROCEDURE

A. Board of Directors Appropriation: Except in emergency circumstances, as set forth CalOptima Health Policy GA.5002: Purchasing, no money may be expended for any purpose unless that money has been appropriated by the Board of Directors, through the operating or capital budget or individual Board action, and the subject matter of the expenditure has been approved by the Board of Directors, as set forth in this Policy.

Back to Agenda Back to Item

B. Board of Directors Approval: Except as specified in this policy, no document binding CalOptima Health shall be entered into except pursuant to the approval of the CalOptima Health Board of Directors. In approving, the Board may delegate to a CalOptima Health officer the authority to enter into agreements that memorialize or are related to the approved action, subject to the assistance of legal counsel, rather than approving a specific binding document. Such approval must be through one of the following means:

1. Individual Board Action: To constitute an authorization though individual Board action, that action must either identify the subject matter of the authorization with reasonable specificity to allow the Board to make an informed decision and to allow staff to proceed without requiring any further fundamental policy decisions to be made, and must specify the nature and scope of that subject matter, such as amount, duration, reporting, or other limitations or requirements, as may be appropriate to the subject matter. Documents regarding arrangements in which the compensation is based in any part on monies recovered or costs avoided by the arrangement (contingency fee contracts) may only be entered into on the basis of a specific, individual Board action.

2. Operational or Capital Budget: To constitute an authorization through inclusion in CalOptima Health's operational or capital budget, expenditures must appear in a budget line item presented to the Board, be related to a Board-approved program or service, and meet the following requirements:

   a. Healthcare goods and services (for the direct provision of Covered Services*): The Board of Directors must approve, in the operating budget, an amount related to the healthcare or related service, and the expenditure must be pursuant to the criteria approved by the Board in an individual Board action, such as rates or rate methodologies, when adopted.

   b. Non-healthcare-related goods and non-professional services: To constitute an authorization through inclusion in the operating or capital budget, non-healthcare-related goods, non-professional services or other expenditure items must appear in a budget line item presented to the Board, specifying the following:

      i. The description of specific goods, services or other expenditure;

      ii. The number or duration of the goods, services or other expenditure items if available; and

      iii. The dollar amount of the expenditure.

   c. Non-medical professional services: Excluding those professional services contracts that must be authorized by direct Board action for legal or policy reasons, to constitute an authorization through inclusion in the operational or capital budget, non-medical professional services expenditure items must appear in a budget line item presented to the Board, specifying the following:

      i. The specific type of professional services to be obtained (e.g., actuarial, legal, management consulting, program evaluation, etc.), and the type of firm that would provide them (e.g., law firm, consultant, architect, engineer, etc.);

      ii. The objective of the professional services; and

      iii. The amount of the expenditure.

C. Board of Directors: The Board authorizes the CEO to enter into a document binding CalOptima Health under the following circumstances:

1. An amendment to a contract with the Department of Health Care Services (DHCS) or the Centers for Medicare & Medicaid Services (CMS) if that amendment:

   a. Contains only non-substantive changes, as determined by legal counsel;

   b. Contains only changes made to comply with existing law, as determined by legal counsel; and

   c. Does not contain rate changes.

2. A CalOptima Health Policy and Procedure (P&P) if that P&P contains:

   a. ~~Contains only n~~Non-substantive changes~~, as determined by legal counsel~~; or~~and~~

   b. ~~Contains only changes made to comply with existing law, as determined by legal counsel~~Substantive changes in compliance with contractual requirements subject to legal review and concurrence.

D. Signature Authority: Documents executed pursuant to Board Authority, as identified in Section III.B of this Policy, may only be executed by the person expressly authorized to sign.

1. For authorizations that specify the signature authority in individual CalOptima Health Board Action Agenda Referral (COBAR), all related binding documents shall be executed by the person expressly authorized to sign.

2. For authorizations that do not specify the signature authority in individual COBAR, all related binding documents shall be executed as follows:

   a. Healthcare goods and services: For binding documents (such as contracts, amendments, consents to assignment, and Letters of Agreement (LOA)), including all those related to procurement of any goods and services that are Covered Services under any of CalOptima Health's lines of business, (e.g., those items budgeted under Section III.B.2.a):

      i. Except as provided in subsection ii of this Section, execution shall be by the Chief Executive Officer (CEO) or the Chief Operating Officer (COO).

      ii. For CalOptima Health Direct (COD) contracts that contain no changes from the standard boilerplate contract and are for rates that do not exceed the Board of Director approved rates for the healthcare goods and services, execution may be by the CEO, COO, or the Executive Director, Network Operations.

   b. Budget and Vendor Management Department binding documents (such as contracts, amendments, consents to assignment, and purchase orders), for non-healthcare-related goods and services (e.g., those items budgeted under Sections III.B.2.b and III.B.2.c) shall be executed by the:

      i. CEO and the Chief Financial Officer (CFO), for documents involving an amount of two hundred fifty thousand dollars ($250,000) or more;

a) For those contracts of two hundred fifty thousand dollars ($250,000) or more, the COO shall have delegated signature authority in the absence of either the CFO or the CEO.

ii. CEO for documents for less than two hundred fifty thousand dollars ($250,000);

iii. CFO for documents for one hundred thousand dollars ($100,000) or less;

iv. Controller or the Director of Budget and Procurement for documents for twenty-five thousand dollars ($25,000) or less; and

v. Purchasing Manager for documents for ten thousand dollars ($10,000) or less.

vi. Price term modifications in documents where payment is on a time and materials or per item basis, and that do not exceed ten percent (10%) of the original price term, either separately or cumulative, may be executed based on the price term increase amount. All other document modifications must be executed in the same manner as the original contract.

c. Emergency expenditure binding documents, related to emergency expenditures, as defined in CalOptima Health Policy GA.5002: Purchasing, shall be executed by the CEO or his or her Designee.

d. Government program contracts, documents that legally or by their terms require the signature of the governing body, and real property transaction documents (including leases) shall be executed by the Chair of the Board of Directors.

e. Employee reimbursements must be made, in accordance with the CalOptima Health Policy GA.5004: Travel and Business Meal Policy.

f. All Other binding documents (e.g., Memoranda of Understanding (MOU), Settlement Agreements, etc.) shall be executed by the CEO or Chair of the Board of Directors.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy GA.5002: Purchasing
B. CalOptima Health Policy GA.5004: Travel and Business Meal Policy

VI. REGULATORY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/01/2012	Regular Meeting of the CalOptima Board of Directors
09/19/2019	Regular Meeting of the CalOptima Finance & Audit Committee

Date	Meeting
10/03/2019	Regular Meeting of the CalOptima Board of Directors
08/04/2022	Regular Meeting of the CalOptima Health Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2012	GA.3202	CalOptima Signature Authority	Administrative
Revised	07/01/2012	GA.3202	CalOptima Signature Authority	Administrative
Revised	03/01/2013	GA.3202	CalOptima Signature Authority	Administrative
Revised	10/03/2019	GA.3202	CalOptima Signature Authority	Administrative
Revised	10/01/2020	GA.3202	CalOptima Signature Authority	Administrative
Revised	08/04/2022	GA.3202	CalOptima Health Signature Authority	Administrative
Revised	04/01/2023	GA.3202	CalOptima Health Signature Authority	Administrative
Revised	TBD	GA.3202	CalOptima Health Signature Authority	Administrative

IX. GLOSSARY

Term	Definition
CalOptima Health Direct (COD)	A direct health care program operated by CalOptima Health that includes both COD-Administrative (COD-A) and CalOptima Health Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment In/Eligibility with CalOptima Health Direct.
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima Health's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Health Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. PACE: Medical services, equipment, or supplies that CalOptima Health is obligated to provide to Participants under the provisions of Welfare & Institutions Code section 14132 and the CalOptima Health PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
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.
Letter of Agreement (LOA)	An agreement with a specific Provider regarding the provision of a specific Covered Service to a Member in the absence of a Contract for the provision of such Covered Service.
Memorandum of Understanding (MOU)	An agreement between CalOptima Health and an external agency, which delineates responsibilities for coordinating care for Members.

Policy:	GA.3202
Title:	**CalOptima Health Signature Authority**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	03/01/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

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B. No document of any type whatsoever that binds CalOptima Health to undertake or refrain from undertaking any action, or to expend any CalOptima Health funds, shall be entered into except pursuant to this Policy.

C. In order for any document to bind CalOptima Health, the Board of Directors must have: (1) appropriated funds for the purpose identified in that document, (2) authorized the subject matter of the underlying action, and (3) the document must be executed by an authorized CalOptima Health representative, as identified in this Policy.

D. Amendments or other changes to any document binding CalOptima Health must be approved and executed in the same manner as the original document, except for minor price deviations, as provided within this Policy.

III. PROCEDURE

A. Board of Directors Appropriation: Except in emergency circumstances, as set forth CalOptima Health Policy GA.5002: Purchasing, no money may be expended for any purpose unless that money has been appropriated by the Board of Directors, through the operating or capital budget or individual Board action, and the subject matter of the expenditure has been approved by the Board of Directors, as set forth in this Policy.

Back to Agenda Back to Item

B. Board of Directors Approval: Except as specified in this policy, no document binding CalOptima Health shall be entered into except pursuant to the approval of the CalOptima Health Board of Directors. In approving, the Board may delegate to a CalOptima Health officer the authority to enter into agreements that memorialize or are related to the approved action, subject to the assistance of legal counsel, rather than approving a specific binding document. Such approval must be through one of the following means:

1. Individual Board Action: To constitute an authorization though individual Board action, that action must either identify the subject matter of the authorization with reasonable specificity to allow the Board to make an informed decision and to allow staff to proceed without requiring any further fundamental policy decisions to be made, and must specify the nature and scope of that subject matter, such as amount, duration, reporting, or other limitations or requirements, as may be appropriate to the subject matter. Documents regarding arrangements in which the compensation is based in any part on monies recovered or costs avoided by the arrangement (contingency fee contracts) may only be entered into on the basis of a specific, individual Board action.

2. Operational or Capital Budget: To constitute an authorization through inclusion in CalOptima Health's operational or capital budget, expenditures must appear in a budget line item presented to the Board, be related to a Board-approved program or service, and meet the following requirements:

   a. Healthcare goods and services (for the direct provision of Covered Services*): The Board of Directors must approve, in the operating budget, an amount related to the healthcare or related service, and the expenditure must be pursuant to the criteria approved by the Board in an individual Board action, such as rates or rate methodologies, when adopted.

   b. Non-healthcare-related goods and non-professional services: To constitute an authorization through inclusion in the operating or capital budget, non-healthcare-related goods, non-professional services or other expenditure items must appear in a budget line item presented to the Board, specifying the following:

      i. The description of specific goods, services or other expenditure;

      ii. The number or duration of the goods, services or other expenditure items if available; and

      iii. The dollar amount of the expenditure.

   c. Non-medical professional services: Excluding those professional services contracts that must be authorized by direct Board action for legal or policy reasons, to constitute an authorization through inclusion in the operational or capital budget, non-medical professional services expenditure items must appear in a budget line item presented to the Board, specifying the following:

      i. The specific type of professional services to be obtained (e.g., actuarial, legal, management consulting, program evaluation, etc.), and the type of firm that would provide them (e.g., law firm, consultant, architect, engineer, etc.);

      ii. The objective of the professional services; and

      iii. The amount of the expenditure.

C. Board of Directors: The Board authorizes the CEO to enter into a document binding CalOptima Health under the following circumstances:

1. An amendment to a contract with the Department of Health Care Services (DHCS) or the Centers for Medicare & Medicaid Services (CMS) if that amendment:

   a. Contains only non-substantive changes, as determined by legal counsel;

   b. Contains only changes made to comply with existing law, as determined by legal counsel; and

   c. Does not contain rate changes.

2. A CalOptima Health Policy and Procedure (P&P) if that P&P contains:

   a. Non-substantive changes; or

   b. Substantive changes in compliance with contractual requirements subject to legal review and concurrence.

D. Signature Authority: Documents executed pursuant to Board Authority, as identified in Section III.B of this Policy, may only be executed by the person expressly authorized to sign.

1. For authorizations that specify the signature authority in individual CalOptima Health Board Action Agenda Referral (COBAR), all related binding documents shall be executed by the person expressly authorized to sign.

2. For authorizations that do not specify the signature authority in individual COBAR, all related binding documents shall be executed as follows:

   a. Healthcare goods and services: For binding documents (such as contracts, amendments, consents to assignment, and Letters of Agreement (LOA)), including all those related to procurement of any goods and services that are Covered Services under any of CalOptima Health's lines of business, (e.g., those items budgeted under Section III.B.2.a):

      i. Except as provided in subsection ii of this Section, execution shall be by the Chief Executive Officer (CEO) or the Chief Operating Officer (COO).

      ii. For CalOptima Health Direct (COD) contracts that contain no changes from the standard boilerplate contract and are for rates that do not exceed the Board of Director approved rates for the healthcare goods and services, execution may be by the CEO, COO, or the Executive Director, Network Operations.

   b. Budget and Vendor Management Department binding documents (such as contracts, amendments, consents to assignment, and purchase orders), for non-healthcare-related goods and services (e.g., those items budgeted under Sections III.B.2.b and III.B.2.c) shall be executed by the:

      i. CEO and the Chief Financial Officer (CFO), for documents involving an amount of two hundred fifty thousand dollars ($250,000) or more;

a) For those contracts of two hundred fifty thousand dollars ($250,000) or more, the COO shall have delegated signature authority in the absence of either the CFO or the CEO.

ii. CEO for documents for less than two hundred fifty thousand dollars ($250,000);

iii. CFO for documents for one hundred thousand dollars ($100,000) or less;

iv. Controller or the Director of Budget and Procurement for documents for twenty-five thousand dollars ($25,000) or less; and

v. Purchasing Manager for documents for ten thousand dollars ($10,000) or less.

vi. Price term modifications in documents where payment is on a time and materials or per item basis, and that do not exceed ten percent (10%) of the original price term, either separately or cumulative, may be executed based on the price term increase amount. All other document modifications must be executed in the same manner as the original contract.

c. Emergency expenditure binding documents, related to emergency expenditures, as defined in CalOptima Health Policy GA.5002: Purchasing, shall be executed by the CEO or his or her Designee.

d. Government program contracts, documents that legally or by their terms require the signature of the governing body, and real property transaction documents (including leases) shall be executed by the Chair of the Board of Directors.

e. Employee reimbursements must be made, in accordance with the CalOptima Health Policy GA.5004: Travel and Business Meal Policy.

f. All Other binding documents (e.g., Memoranda of Understanding (MOU), Settlement Agreements, etc.) shall be executed by the CEO or Chair of the Board of Directors.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy GA.5002: Purchasing
B. CalOptima Health Policy GA.5004: Travel and Business Meal Policy

VI. REGULATORY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/01/2012	Regular Meeting of the CalOptima Board of Directors
09/19/2019	Regular Meeting of the CalOptima Finance & Audit Committee
10/03/2019	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
08/04/2022	Regular Meeting of the CalOptima Health Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2012	GA.3202	CalOptima Signature Authority	Administrative
Revised	07/01/2012	GA.3202	CalOptima Signature Authority	Administrative
Revised	03/01/2013	GA.3202	CalOptima Signature Authority	Administrative
Revised	10/03/2019	GA.3202	CalOptima Signature Authority	Administrative
Revised	10/01/2020	GA.3202	CalOptima Signature Authority	Administrative
Revised	08/04/2022	GA.3202	CalOptima Health Signature Authority	Administrative
Revised	04/01/2023	GA.3202	CalOptima Health Signature Authority	Administrative
Revised	TBD	GA.3202	CalOptima Health Signature Authority	Administrative

IX. GLOSSARY

Term	Definition
CalOptima Health Direct (COD)	A direct health care program operated by CalOptima Health that includes both COD-Administrative (COD-A) and CalOptima Health Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment In/Eligibility with CalOptima Health Direct.
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima Health's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Health Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. PACE: Medical services, equipment, or supplies that CalOptima Health is obligated to provide to Participants under the provisions of Welfare & Institutions Code section 14132 and the CalOptima Health PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
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.
Letter of Agreement (LOA)	An agreement with a specific Provider regarding the provision of a specific Covered Service to a Member in the absence of a Contract for the provision of such Covered Service.
Memorandum of Understanding (MOU)	An agreement between CalOptima Health and an external agency, which delineates responsibilities for coordinating care for Members.

CalOptima Health Board Action Agenda Referral

Action To Be Taken September 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

6. Approve New CalOptima Health Policy GG.1630: Reporting Communicable Diseases

Contacts

Linda Lee, Executive Director, Quality Improvement (657) 900-1069
Marsha Choo, Director, Quality Improvement (714) 246-8670

Recommended Actions

Approve new CalOptima Health Policy GG.1630: Reporting Communicable Diseases.

Background/Discussion

CalOptima Health establishes new policies and procedures to implement federal and state laws, program regulations, contracts, and business practices. Additionally, CalOptima Health staff performs annual policy reviews to add or update internal policies and procedures to ensure compliance with applicable requirements.

The purpose of the new policy is to comply with the 2024 DHCS Contract readiness provisions, which require CalOptima Health to report any serious diseases or conditions to local and state public health authorities. The contract also requires CalOptima Health to maintain procedures to implement directives from the public health authorities as required by law, including but not limited to, Title 17, California Code of Regulations (CCR), Section 2500 *et seq*.

Fiscal Impact

The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the Fiscal Year 2023-2024 Operating Budget.

Rationale for Recommendation

CalOptima Health staff recommends that the Board approve new policy GG.1630 to ensure CalOptima Health's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Health Policy GG.1630: Reporting Communicable Diseases

/s/ Michael Hunn *08/31/2023*
Authorized Signature **Date**

Back to Agenda

Policy:	GG.1630p
Title:	**Reporting Communicable Diseases**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/*
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines procedures for reporting any serious diseases or conditions to both local and State public health authorities, and to implement directives from the public health authorities as required by law, including but not limited to, Title 17, California Code of Regulations (CCR), Section §2500 et seq.

II. POLICY

A. CalOptima Health and its Health Networks shall ensure that all contracted health care Providers and laboratories report known or suspected cases of disease or condition to the jurisdiction in which the Member resides as mandated by California state law, Title 17, California Code of Regulations (CCR), Section §2500 et seq.

III. PROCEDURE

A. CalOptima Health and its Health Networks shall inform contracted Providers of their responsibility to report suspected case(s) of any diseases or conditions listed in Title 17, California Code of Regulations (CCR), Section §2500, to the local health officer.

1. A health care Provider shall report suspected case(s) of any disease or conditions listed in Title 17, California Code of Regulations (CCR), Section §2500, to the local health officer.

2. When no health care Provider is in attendance at the provider office or laboratory, any individual working for the provider office or laboratory having knowledge of the suspected case of the disease or condition listed in Title 17, California Code of Regulations (CCR), Section §2500, shall make a report to the local health officer.

3. The administrator of each health facility, clinic, or other setting where more than one health care Provider may know of a suspected case of the disease or condition listed in Title 17, California Code of Regulations (CCR), Section §2500, shall establish and be responsible for administrative procedures to assure that reports are made to the local health officer.

Back to Agenda Back to Item

B. All CalOptima Health and its Health Networks and laboratories shall report known or suspected cases of disease or conditions to the jurisdiction in which the Member resides.

1. A list of reportable diseases, reporting timeframes, and reporting methods are available from the California Department of Public Health website under the Division of Communicable Disease Control, Reportable Diseases and Conditions website.

C. The report to the public health authorities shall be documented in the Member's Medical Record and include the report date, the contact at the public health authority, and the reporter's signature.

D. Local Health Departments (LHD) are responsible for receiving disease reports and coordinating follow-up action between local, regional, and state officials. In some cases, reporting requirements may differ slightly from one county to the next. Questions about communicable disease reporting should be directed to the LHD.

Orange County Local Health Department:
P.O. Box 6128
Santa Ana, CA, 92706-0128
Phone: (714) 834-8180
Fax: (714) 834-8196

E. CalOptima Health shall implement directives from the public health authorities.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Department of Public Health, Division of Communicable Disease Control Reportable Diseases and Conditions: Reportable Diseases PDF (Revised August 2022)
B. Title 17, California Code of Regulations (CCR), §2500 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

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

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	GG.1630	Reporting Communicable Diseases	Medi-Cal OneCare PACE

Back to Agenda Back to Item

IX. GLOSSARY

Term	Definition
Medical Record	Medi-Cal: Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima Health policy. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	A beneficiary enrolled in a CalOptima Health program.
Provider	Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, nonphysician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.

CalOptima Health Board Action Agenda Referral

Action To Be Taken September 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Authorize and Direct Execution of a new "Companion Contract" with the California Department of Health Care Services for the CalOptima Health Program of All-Inclusive Care for the Elderly

Contacts

John Tanner, Chief Compliance Officer, (657) 235-6997
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new "Companion Contract" (*State Only Agreement*) to the Primary Contract for Program of All-Inclusive Care for the Elderly (PACE) between the California Department of Health Care Services (DHCS) and CalOptima Health, with a contract term of January 1, 2023 to December 31, 2025.

Background

Since October 2009, the CalOptima Health Board has taken numerous actions related to the CalOptima Health PACE program. On June 6, 2013, the Board authorized the execution of the PACE agreement between DHCS and CalOptima Health (DHCS PACE Agreement - "Primary Contract"), as well as the agreement with the Centers for Medicare & Medicaid Services (CMS) for the operation of the CalOptima Health PACE site. Beginning in September 2015, the Board has authorized execution of various amendments to the Primary Contract for calendar year (CY) payment rates and other provisions, as summarized in the attached Appendix.

The Primary Contract specifies, among other terms and conditions, the capitation payment rates CalOptima Health receives from DHCS to provide PACE participants with health care services, with the capitation rates renewed on a CY basis. The current Primary Contract expires on December 31, 2025.

Discussion

On July 28, 2023, DHCS provided CalOptima Health with a new agreement, referred to as "Companion Contract", for PACE Plan's signature at the earliest opportunity. The need for this separate Companion Contract is stemming from the eligibility criteria changes in the Medi-Cal program for the Older Adult Expansion (*i.e.,* 50 years old and above regardless of immigration status).

This new Companion Contract would be in addition to the existing Primary Contract, with the difference that the Companion Contract will be for coverage of those members that are considered Unsatisfactory Immigration Status but State Funded (UIS State-Only). DHCS will provide coverage for these members without the federal funds match in capitation. The Companion Contract is similar to the DHCS Medi-Cal Secondary Agreement for Medi-Cal services that are funded only through state dollars. The Medi-Cal Secondary Agreement ties into to the DHCS Medi-Cal Primary Agreement. The Board approved the Medi-Cal Secondary Agreement at its December 2022 meeting and the agreement was signed in February 2023.

Back to Agenda

The following are the significant provisions from the Companion Contract for PACE:

- Effective January 1, 2023, through the contract termination of December 31, 2025, with the DHCS capitation rates for the UIS population renewed on a CY basis.
- The same amount for the DHCS PACE capitation rate (Medi-Cal only population) will be paid for the UIS population to PACE retroactive to January 1, 2023. Payments for the Companion Contract will begin after August 1, 2023. After August 1, 2023, retroactive payments will be issued for the months back to January 2023.
- DHCS will establish capitation payment rates on an actuarial basis, and that basis will be set forth in the DHCS rate certification(s), including any amendment(s) or revision(s), for the applicable rating period. Upon completion, said rate certification(s) are incorporated by reference and made a part of the Companion Contract.
- The Unsatisfactory Immigration Status but Subject to Federal Match, and Satisfactory Immigration Status population will continue to be covered under the existing Primary Contract.
- Under the Companion Contract, all services covered under the PACE benefit of the Medi-Cal program as described in the Primary Contract, will be provided to UIS State-Only Members enrolled under the Primary Contract in the same manner and subject to the same requirements as described in the Primary Contract, except as described in the Companion Contract.
- Private services described in the Companion Contract will be provided to all PACE members enrolled in the Primary Contract, in the same manner as described in the Primary Contract.
- In providing services under the Companion Contract, CalOptima Health PACE must provide services and interact with UIS State-Only members on an equal basis as with members covered under the Primary Contract. The CalOptima Health PACE network providers and subcontractors are required to cover and provide services to UIS State-Only members in a manner that is indistinguishable from the rest of members covered under the Primary Contract.
- The provision of pregnancy-related services and emergency services are excluded from coverage under the Companion Contract, as they remain covered as described in the Primary Contract.
- Requirement for compliance with California Governor's Executive Order N-6-22 regarding the Economic Sanctions against Russia and Russian entities and individuals.

CalOptima Health staff commits to return to the Board, if needed, if there are any further updates to the Companion Contract that are materially different from the current version.

Fiscal Impact

The recommended action to enter into the Companion Contract for PACE UIS State-Only members to provide the same level of benefits at the same DHCS rate has no additional fiscal impact to the CalOptima Health Fiscal Year (FY) 2023-24 Operating Budget approved by the Board on June 1, 2023.

Rationale for Recommendation

CalOptima Health's execution of the new "Companion Contract" is necessary for the continued operation of CalOptima Health PACE.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Back to Agenda

Attachments

1. Appendix 1: Summary of Amendments to PACE Primary Agreement

/s/ Michael Hunn *08/31/2023*
Authorized Signature **Date**

Back to Agenda

APPENDIX TO AGENDA ITEM 7

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

Amendments to Primary Agreement with DHCS	Board Approval
A01 provided revised Upper Payment Limit (UPL) and capitation rates for Calendar Year (CY) 2013 for the period of October 1, 2013 through December 31, 2013; and UPL methodology and CY 2014 rates for the period of January 1, 2014 through December 31, 2014. Revised capitation rates for the Medi-Cal *Dual* population and *Medi-Cal only* population to have built-in adjustments for Medi-Cal program changes. Also incorporated adult expansion group into aid code table: a. Added adult expansion aid codes M1, L1, 7U under adult expansion group. b. Added aid codes 3D and M3 under Family group.	September 3, 2015
A02 provided revised UPL and capitation rates for CY 2015 for the period of January 1, 2015 through December 31, 2015. Revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population to have built-in adjustments for Medi-Cal program changes.	September 3, 2015
A03 provided revised UPL and capitation rates for CY 2016 for the period of January 1, 2016 through December 31, 2016, and applied the Managed Care Organization (MCO) Tax for the period July 1, 2016 through December 31, 2016. Beginning on January 1, 2017 and onward, the rates revert back to the non-MCO tax period rates in effect from January 1, 2016 through June 30, 2016, until the 2017 rates are developed and implemented with a future amendment to the CalOptima DHCS PACE Agreement. Incorporates a revised HIPAA Business Associate Addendum, Exhibit H, to replace the former Exhibit G, as of the Amendment effective date, which will require compliance with DHCS' revised data security standards.	May 4, 2017
Amend* contract to include revised language reflecting the Americans with Disabilities Act (ADA) for 508 compliance. *On 9/20/17, DHCS informed CalOptima this would be moved to be captured in A04.	August 3, 2017
A04 provided an extension of the contract termination date to December 31, 2018 and incorporated ADA compliance language.	December 7, 2017
Future Amendment (A05) provided draft capitation rates for CY 2017 for the period of January 1, 2017 through December 31, 2017, developed by the "Amount That Would Have Otherwise Been Paid (AWOP)", and apply the Managed Care Organization (MCO) Tax for the period January 1, 2017 through June 30, 2017.	December 7, 2017

Back to Agenda Back to Item

Amendments to Primary Agreement with DHCS	Board Approval
A06 provided an extension of the contract termination date to December 31, 2019.	November 1, 2018
A07 provided revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2018 for the period of January 1, 2018 through December 31, 2018 and applies the Managed Care Organization (MCO) Tax for this period. First time rates for PACE developed using the Rate Development Template (RDT)/experience-based rate methodology. Incorporates additional language updates for various contract provisions, including restrictions on delegation as well as emergency preparedness.	April 4, 2019
A08 provided revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2019 for the period of January 1, 2019 through December 31, 2019 and applies the Managed Care Organization (MCO) Tax for this period. Incorporates additional language updates for other contract provisions, including Nursing Facility Services payment rates.	September 5, 2019
A09 provided an extension of the contract termination date to June 30, 2020.	December 5, 2019
A10 provided an extension of the contract termination date to December 31, 2020 and also provides revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2020 for the period of January 1, 2020 through December 31, 2020.	June 4, 2020
New Primary Agreement: Replaces the previous contract and subsequent amendments in their entirety, effective January 1, 2021. Also extends the contract termination date to December 31, 2024, with DHCS capitation rates renewed on a calendar year basis. The new agreement aligns the PACE DHCS agreement with: • provisions contained in the Managed Care Plan (MCP) Medi-Cal contracts; and • provisions in the CMS 2019 Final Rule.	November 5, 2020
A01 provided an extension of the contract termination date to December 31, 2025 and also provides revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2022 for the period of January 1, 2022 through December 31, 2022 Incorporates Aid Code 38 as an eligible Aid Code for PACE and modifies numbering for provisions throughout the Exhibits, to correct contract cross-references or correct regulatory citations.	November 3, 2022
Amendments to Primary Agreement with CMS	**Board Approval**
A01 CalOptima PACE initiated a waiver to allow Nurse Practitioners to provide primary care at PACE, which was approved by CMS on March 30, 2017 and added *Appendix T: Regulatory Waivers* to the CMS PACE Agreement.	December 1, 2016
A02 CalOptima PACE initiated a waiver to allow Community Based Physicians to Serve as the Primary Care Provider for Participants Enrolled in CalOptima PACE, which was approved by CMS on March 12, 2018 and amended *Appendix T: Regulatory Waivers* to the CMS PACE Agreement.	September 7, 2017

The following is a summary of amendments to the PACE "Companion Contract" Agreement approved by the CalOptima Board of Directors (Board) to date:

Amendments to "Companion Contract" Agreement with DHCS	Board Approval
Initial effective 1/1/23 provides coverage for Unsatisfactory Immigration Status (UIS) population.	Pending

CalOptima Health Board Action Agenda Referral

Action To Be Taken September 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

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

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

Recommended Action
The CalOptima Health Member Advisory Committee (MAC) recommends the appointment of Nicole Mastin to serve a remaining term on the MAC as the CalWORKs Representative, effective September 7, 2023, and ending June 30, 2026.

Background
The CalOptima Health Board of Directors (Board) established the MAC by resolution on February 14, 1995, to provide input to the Board. The MAC is comprised of 15 voting members with 14 MAC members serving three-year terms and one standing seat for the representative from the County of Orange Social Services Agency (SSA). The Board is responsible for the appointment of all MAC members.

Discussion
In June 2023, CalOptima Health received notification that the CalWORKs Representative seat would become open due to the transfer of job responsibilities within the Orange County SSA of the then current CalWORKs Representative. The SSA, which has oversight for CalWORKs in Orange County, assisted CalOptima Health in recruiting a qualified applicant for the open MAC seat.

The MAC Nominations Ad Hoc Subcommittee, composed of MAC committee members Vice Chair Christine Tolbert and members Iliana Soto Welty and Lee Lombardo, evaluated the applicant and submitted a recommendation to the MAC at the August 10, 2023 MAC meeting.

The MAC recommends that Nicole Mastin be appointed as the CalWORKs Representative.

CalWORKs Representative
Nicole Mastin
Nicole Mastin is the Human Services Manager at the Orange County SSA, CalWORKs Policy and Quality Assurance division. Ms. Mastin participates in multidisciplinary meetings with CalWORKs clients along with partner agencies to determine available resources to assist clients in overcoming a multitude of barriers.

Fiscal Impact
There is no fiscal impact.

Back to Agenda

Rationale for Recommendation

As stated in policy AA.1219a, the MAC established a Nominations Ad Hoc Subcommittee to review the potential candidate for the CalWORKs vacancy on the committee. The MAC met to discuss the Nominations Ad Hoc Subcommittee's recommendation and concurred with the subcommittee's recommendations. The MAC now forwards the recommended candidate to the Board for consideration.

Concurrence

Member Advisory Committee
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

None

/s/ Michael Hunn *08/31/2023*
Authorized Signature **Date**

Back to Agenda

Financial Summary

July 31, 2023

Board of Directors Meeting
September 7, 2023

Nancy Huang, Chief Financial Officer

Our Mission

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

Our Vision

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

Back to Agenda

Financial Highlights: July 2023

	Actual	Budget	$ Variance	% Variance
Member Months	979,618	992,422	(12,804)	(1.3%)
Revenues	362,777,779	362,111,870	665,909	0.2%
Medical Expenses	318,962,339	336,362,133	17,399,794	5.2%
Administrative Expenses	16,784,946	20,011,467	3,226,521	16.1%
Operating Margin	27,030,494	5,738,270	21,292,224	371.1%
Total Non-Operating Income (Loss)	13,296,361	1,047,398	12,248,964	1169.5%
Change in Net Assets	**40,326,855**	**6,785,668**	**33,541,188**	**494.3%**
Medical Loss Ratio	*87.9%*	*92.9%*	*(5.0%)*	
Administrative Loss Ratio	*4.6%*	*5.5%*	*0.9%*	

Back to Agenda

CalOptima Health

FY 2023-24: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) July 2023: $40.3 million, favorable to budget $33.5 million or 494.3% driven primarily from lower-than-expected utilization and favorable net investment income

- Enrollment
  - MTD: 979,618 members, unfavorable to budget 12,804 or 1.3%
  - Unfavorable enrollment primarily driven by high disenrollment and retroactive enrollment adjustments

Back to Agenda

CalOptima Health

FY 2023-24:Management Summary (cont.)

- Revenue
  - MTD: $362.8 million, favorable to budget $0.7 million or 0.2% driven by Medi-Cal Line of Business (MC LOB)

- Medical Expenses
  - MTD: $319.0 million, favorable to budget $17.4 million or 5.2% driven by MC LOB:
    - Primarily due to lower-than-expected utilization in Facilities and Managed Long-Term Services and Supports (MLTSS) claims

Back to Agenda

CalOptima Health

FY 2023-24:Management Summary (cont.)

- Administrative Expenses
  - MTD: $16.8 million, favorable to budget $3.2 million or 16.1%
    - Other Non-Salary expenses favorable variance of $2.7 million
    - Salaries & Benefits expense favorable variance of $0.6 million

- Non-Operating Income (Loss)
  - MTD: $13.3 million, favorable to budget $12.2 million or 1,169.5%
    - Net Investment Income favorable variance of $12.1 million

Back to Agenda

CalOptima Health

FY 2022-23: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 87.9%, Budget 92.9%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 4.6%, Budget 5.5%
- Balance Sheet Ratios
  - Current ratio*: 1.6
  - Board Designated Reserve level: 1.77
  - Net-position: $1.7 billion, including required Tangible Net Equity (TNE) of $108.2 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations

Back to Agenda

CalOptima Health

Enrollment Summary: July 2023

Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
SPD	142,819	142,604	215	0.2%
TANF Child	301,907	319,348	(17,441)	(5.5%)
TANF Adult	142,582	134,693	7,889	5.9%
LTC	3,011	3,118	(107)	(3.4%)
MCE	359,793	363,246	(3,453)	(1.0%)
WCM	11,382	11,359	23	0.2%
Medi-Cal Total	**961,494**	**974,368**	**(12,874)**	**(1.3%)**
OneCare	**17,695**	**17,601**	**94**	**0.5%**
OneCare Connect	**0**	**0**	**0**	**0.0%**
PACE	**429**	**453**	**(24)**	**(5.3%)**
MSSP	**503**	**568**	**(65)**	**(11.4%)**
CalOptima Health Total	**979,618**	**992,422**	**(12,804)**	**(1.3%)**

*CalOptima Health Total does not include MSSP

Back to Agenda

CalOptima Health

Consolidated Revenue & Expenses: July 2023 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	590,319	359,793	11,382	961,494	17,947	-	429	503	979,870
REVENUES									
Capitation Revenue	173,053,292	$ 134,409,918	$ 20,688,356	$ 328,151,566	$ 30,746,673	$ 60,466	$ 3,597,237	$ 221,837	$ 362,777,779
Total Operating Reven	**173,053,292**	**134,409,918**	**20,688,356**	**328,151,566**	**30,746,673**	**60,466**	**3,597,237**	**221,837**	**362,777,779**
MEDICAL EXPENSES									
Provider Capitation	52,767,194	49,443,192	8,100,748	110,311,134	12,394,220				122,705,353
Claims	59,704,670	44,650,824	7,148,315	111,503,809	7,383,175	(30,996)	1,596,133		120,452,120
MLTSS	37,930,952	5,030,951	1,609,140	44,571,043	81,791	(1,934)	(20,214)	14,975	44,645,660
Prescription Drugs	-		(8,490)	(8,490)	7,809,050	(207)	418,853		8,219,205
Case Mgmt & Other Medic	11,583,466	8,520,064	599,746	20,703,276	964,596	30,529	1,105,789	135,811	22,940,001
Total Medical Expense	**161,986,282**	**107,645,031**	**17,449,458**	**287,080,771**	**28,632,831**	**(2,608)**	**3,100,559**	**150,786**	**318,962,339**
Medical Loss Ratio	*93.6%*	*80.1%*	*84.3%*	*87.5%*	*93.1%*	*-4.3%*	*86.2%*	*68.0%*	*87.9%*
GROSS MARGIN	**11,067,010**	**26,764,887**	**3,238,898**	**41,070,795**	**2,113,843**	**63,074**	**496,677**	**71,051**	**43,815,440**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				10,082,757	1,009,832		140,769	123,348	11,356,706
Non-Salary Operating Expenses				2,166,848	298,679	(4,253)	21,384	1,340	2,483,997
Depreciation & Amortization				841,208			1,086		842,294
Other Operating Expenses				1,689,555	59,199		7,235	123	1,756,111
Indirect Cost Allocation, Occupancy				(624,953)	948,600		14,660	7,530	345,837
Total Administrative Expenses				**14,155,415**	**2,316,309**	**(4,253)**	**185,134**	**132,341**	**16,784,946**
Administrative Loss Ratio				*4.3%*	*7.5%*	*-7.0%*	*5.1%*	*59.7%*	*4.6%*
Operating Income/(Loss)				**26,915,380**	**(202,466)**	**67,327**	**311,543**	**(61,290)**	**27,030,494**
Investments and Other Non-Operating				(946,970)					13,296,361
CHANGE IN NET ASSETS				**$ 25,968,410**	**$ (202,466)**	**$ 67,327**	**$ 311,543**	**$ (61,290)**	**$ 40,326,855**
BUDGETED CHANGE IN NET ASSETS				6,895,101	(2,187,911)	-	96,068	(68,207)	6,785,668
Variance to Budget - Fav/(Unfav)				$ 19,073,310	$ 1,985,445	$ 67,327	$ 215,475	$ 6,917	$ 33,541,188

Back to Agenda

CalOptima Health

Balance Sheet: As of July 2023

ASSETS	
Current Assets	
Operating Cash	$551,847,227
Short-term Investments	1,941,670,466
Receivables & Other Current Assets	473,622,873
Total Current Assets	**2,967,140,566**
Capital Assets	
Capital Assets	151,964,325
Less Accumulated Depreciation	(68,019,187)
Capital Assets, Net of Depreciation	83,945,137
Other Assets	
Restricted Deposits	300,000
Board Designated Reserve	578,993,864
Total Other Assets	**579,293,864**
TOTAL ASSETS	**3,630,379,567**
Deferred Outflows	**25,969,350**
TOTAL ASSETS & DEFERRED OUTFLOWS	**3,656,348,917**

LIABILITIES & NET POSITION	
Current Liabilities	
Accounts Payable	$15,219,697
Medical Claims Liability and Capitation Payable	1,659,182,084
Capitation and Withholds	129,515,347
Other Current Liabilities	55,330,989
Total Current Liabilities	**1,859,248,117**
Other Liabilities	
GASB 96 Subscription Liabilities	16,107,717
Postemployment Health Care Plan	19,019,314
Net Pension Liabilities	40,465,145
Total Other Liabilities	**75,592,175**
TOTAL LIABILITIES	**1,934,840,293**
Deferred Inflows	**11,175,516**
Net Position	
TNE	108,222,485
Funds in Excess of TNE	1,602,110,624
TOTAL NET POSITION	**1,710,333,109**
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**3,656,348,917**

Back to Agenda

CalOptima Health

Board Designated Reserve and TNE Analysis: As of July 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	236,057,900				
	Tier 1 - MetLife	234,132,545				
Board Designated Reserve		470,190,445	348,679,779	544,495,035	121,510,666	(74,304,591)
	Tier 2 - Payden & Rygel	54,552,450				
	Tier 2 - MetLife	54,250,970				
TNE Requirement		108,803,419	108,222,485	108,222,485	580,934	580,934
	Consolidated:	**578,993,864**	**456,902,264**	**652,717,520**	**122,091,600**	**(73,723,656)**
	Current reserve level	*1.77*	*1.40*	*2.00*		

Back to Agenda

CalOptima Health

Net Assets Analysis: As of July 2023

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 7/31/2023	**$1,710.3**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**579.0**			**33.9%**
	Capital Assets, net of Depreciation[2]	**83.9**			**4.9%**
Resources Allocated[3]	Homeless Health Initiative[4]	$21.0	$59.9	$38.9	1.2%
	Housing and Homelessness Incentive Program[5]	69.7	97.2	27.5	4.1%
	Intergovernmental Transfers (IGT)	58.7	111.7	53.0	3.4%
	Digital Transformation and Workplace Modernization	98.5	100.0	1.5	5.8%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	Outreach Strategy for CalFresh, Redetermination support, and other programs	6.9	8.0	1.1	0.4%
	Coalition of Orange County Community Health Centers Grant	40.0	50.0	10.0	2.3%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	1.0	1.0	0.0	0.1%
	General Awareness Campaign	1.0	2.7	1.7	0.1%
	Member Health Needs Assessment	1.0	1.0	0.0	0.1%
	Five-Year Hospital Quality Program Beginning MY 2023	151.7	153.5	1.8	8.9%
	Medi-Cal Annual Wellness Initiative	2.4	3.8	1.4	0.1%
	Skilled Nursing Facility Access Program	9.7	10.0	0.3	0.6%
	In-Home Care Pilot Program with the UCI Family Health Center	1.4	2.0	0.6	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	4.5	5.0	0.5	0.3%
	Community Living and PACE Center in the City of Tustin	17.7	18.0	0.3	1.0%
	Stipend Program for Master of Social Works	5.0	5.0	0.0	0.3%
	Wellness & Prevention Program	2.7	2.7	0.0	0.2%
	CalOptima Health Provider Workforce Development Fund	50.0	50.0	0.0	2.9%
	Post-Pandemic Supplemental	107.5	107.5	0.0	6.3%
	Subtotal:	**$650.4**	**$805.0**	**$154.6**	**38.0%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$397.0**			**23.2%**

[1] Total of Board Designated Reserve and unallocated reserve amount can support approximately 90 days of CalOptima Health's current operations
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements
[3] Initiatives that have been paid in full in the previous year are omitted from the list of Resources Allocated
[4] See HHI summary and Allocated Funds for list of Board approved initiatives
[5] On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP (see HHIP Summary)

Back to Agenda

CalOptima Health

Homeless Health Initiative and Allocated Funds: As of July 2023

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Days, HCAP and FQHC Administrative Support	963,261	662,709	300,552
FQHC (Community Health Center) Expansion	21,902	21,902	-
Homeless Clinical Access Program (HCAP) and CalOptima Days	9,888,914	3,170,400	6,718,514
Vaccination Intervention and Member Incentive Strategy	400,000	54,649	345,351
Street Medicine	8,000,000	1,455,500	6,544,500
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[1]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$ 100,000,000**	**$ 38,947,561**	**$ 61,052,439**
Transfer of funds to HHIP[1]	(40,100,000)	-	(40,100,000)
Program Total	**$ 59,900,000**	**$ 38,947,561**	**$ 20,952,439**

Notes:

[1]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP.

Back to Agenda

CalOptima Health

Housing and Homelessness Incentive Program
As of July 2023

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Office of Care Coordination	2,200,000	2,200,000	-
Pulse For Good	800,000	15,000	785,000
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresent	4,021,311	1,461,149	2,560,162
Infrastructure Projects	5,832,314	2,785,365	3,046,949
Capital Projects	73,247,369	21,000,000	52,247,369
System Change Projects	10,180,000	-	10,180,000
Non-Profit Healthcare Academy	354,530	-	354,530
Total of Approved Initiatives	**$ 97,235,524** [1]	**$ 27,461,514**	**$ 69,774,010**

Notes:

[1]Total funding $97.2M: $40.1M Board-approved reallocation from HHI, $22.3M from CalOptima Health existing reserves and $34.8M from DHCS HHIP incentive payments

Back to Agenda

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Back to Agenda

UNAUDITED FINANCIAL STATEMENTS

July 31, 2023

Back to Agenda

Table of Contents

Back to Agenda

CalOptima Health - Consolidated
Financial Highlights
For the One Month Ended July 31, 2023

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
979,618	992,422	(12,804)	(1.3%)	Member Months	979,618	992,422	(12,804)	(1.3%)
362,777,779	362,111,870	665,909	0.2%	Revenues	362,777,779	362,111,870	665,909	0.2%
318,962,339	336,362,133	17,399,794	5.2%	Medical Expenses	318,962,339	336,362,133	17,399,794	5.2%
16,784,946	20,011,467	3,226,521	16.1%	Administrative Expenses	16,784,946	20,011,467	3,226,521	16.1%
27,030,494	**5,738,270**	**21,292,224**	**371.1%**	**Operating Margin**	**27,030,494**	**5,738,270**	**21,292,224**	**371.1%**
				Non-Operating Income (Loss)				
14,217,771	2,083,330	12,134,441	582.5%	Net Investment Income/Expense	14,217,771	2,083,330	12,134,441	582.5%
25,560	(32,713)	58,273	178.1%	Net Rental Income/Expense	25,560	(32,713)	58,273	178.1%
(946,970)	(1,003,219)	56,250	5.6%	Grant Expense	(946,970)	(1,003,219)	56,250	5.6%
13,296,361	**1,047,398**	**12,248,964**	**1169.5%**	**Total Non-Operating Income (Loss)**	**13,296,361**	**1,047,398**	**12,248,964**	**1169.5%**
40,326,855	**6,785,668**	**33,541,188**	**494.3%**	**Change in Net Assets**	**40,326,855**	**6,785,668**	**33,541,188**	**494.3%**
87.9%	92.9%	(5.0%)		Medical Loss Ratio	87.9%	92.9%	(5.0%)	
4.6%	5.5%	0.9%		Administrative Loss Ratio	4.6%	5.5%	0.9%	
7.5%	1.6%	5.9%		Operating Margin Ratio	7.5%	1.6%	5.9%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

CalOptima Health - Consolidated
Full Time Employee Data
For the One Month Ended July 31, 2023

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1248	1352	104
OneCare	183	197	14
PACE	103	101	(2)
MSSP	23	24	1
Total	1556	1673	117

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	770	721	(50)
OneCare	97	89	(8)
PACE	4	5	0
MSSP	22	24	2
Total	630	593	(36)

Open Positions			
	Total	Medical	Admin
Medi-Cal	81.00	29.75	51.25
OneCare	0.00	0.00	0.00
PACE	4.00	3.00	1.00
MSSP	5.00	4.00	1.00
Total	90.00	36.75	53.25

CalOptima Health - Consolidated
Statement of Revenues and Expenses
For the One Month Ended July 31, 2023

	Actual		Budget		Variance	
	$	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
MEMBER MONTHS	979,618		992,422		(12,804)	
REVENUE						
Medi-Cal	$ 328,151,566	$ 341.29	$ 326,526,961	$ 335.12	$ 1,624,605	$ 6.17
OneCare	30,746,673	1,737.59	31,452,719	1,786.98	(706,046)	(49.39)
OneCare Connect	60,466		-		60,466	-
PACE	3,597,237	8,385.17	3,878,672	8,562.19	(281,435)	(177.02)
MSSP	221,837	441.03	253,518	446.33	(31,681)	(5.30)
Total Operating Revenue	362,777,779	370.33	362,111,870	364.88	665,909	5.45
MEDICAL EXPENSES						
Medi-Cal	287,080,771	298.58	301,524,797	309.46	14,444,026	10.88
OneCare	28,632,831	1,618.13	31,029,618	1,762.95	2,396,787	144.82
OneCare Connect	(2,608)				2,608	-
PACE	3,100,559	7,227.41	3,590,049	7,925.05	489,490	697.64
MSSP	150,786	299.77	217,669	383.22	66,883	83.45
Total Medical Expenses	318,962,339	325.60	336,362,133	338.93	17,399,794	13.33
GROSS MARGIN	43,815,440	44.73	25,749,737	25.95	18,065,703	18.78
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	11,356,706	11.59	11,908,686	12.00	551,980	0.41
Professional Fees	522,806	0.53	1,047,040	1.06	524,234	0.53
Purchased Services	1,417,602	1.45	2,034,878	2.05	617,276	0.60
Printing & Postage	543,590	0.55	613,126	0.62	69,537	0.07
Depreciation & Amortization	842,294	0.86	400,900	0.40	(441,394)	(0.46)
Other Expenses	1,756,111	1.79	3,561,958	3.59	1,805,847	1.80
Indirect Cost Allocation, Occupancy	345,837	0.35	444,879	0.45	99,042	0.10
Total Administrative Expenses	16,784,946	17.13	20,011,467	20.16	3,226,521	3.03
INCOME (LOSS) FROM OPERATIONS	27,030,494	27.59	5,738,270	5.78	21,292,224	21.81
INVESTMENT INCOME						
Interest Income	12,331,089	12.59	2,083,330	2.10	10,247,759	10.49
Realized Gain/(Loss) on Investments	(748,265)	(0.76)	-	-	(748,265)	(0.76)
Unrealized Gain/(Loss) on Investments	2,634,947	2.69	-	-	2,634,947	2.69
Total Investment Income	14,217,771	14.51	2,083,330	2.10	12,134,441	12.41
NET RENTAL INCOME	25,560	0.03	(32,713)	(0.03)	58,273	0.06
TOTAL GRANT EXPENSE	(946,970)	(0.97)	(1,003,219)	(1.01)	56,250	0.04
CHANGE IN NET ASSETS	**40,326,855**	**41.17**	**6,785,668**	**6.84**	**33,541,188**	**34.33**
MEDICAL LOSS RATIO	**87.9%**		**92.9%**		**(5.0%)**	
ADMINISTRATIVE LOSS RATIO	**4.6%**		**5.5%**		**0.9%**	

Back to Agenda

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended July 31, 2023

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	590,319	359,793	11,382	961,494	17,947	-	429	503	979,870
REVENUES									
Capitation Revenue	173,053,292	$ 134,409,918	$ 20,688,356	$ 328,151,566	$ 30,746,673	$ 60,466	$ 3,597,237	$ 221,837	$ 362,777,779
Total Operating Revenue	**173,053,292**	**134,409,918**	**20,688,356**	**328,151,566**	**30,746,673**	**60,466**	**3,597,237**	**221,837**	**362,777,779**
MEDICAL EXPENSES									
Provider Capitation	52,767,194	49,443,192	8,100,748	110,311,134	12,394,220				122,705,353
Claims	59,704,670	44,650,824	7,148,315	111,503,809	7,383,175	(30,996)	1,596,133		120,452,120
MLTSS	37,930,952	5,030,951	1,609,140	44,571,043	81,791	(1,934)	(20,214)	14,975	44,645,660
Prescription Drugs	-		(8,490)	(8,490)	7,809,050	(207)	418,853		8,219,205
Case Mgmt & Other Medical	11,583,466	8,520,064	599,746	20,703,276	964,596	30,529	1,105,789	135,811	22,940,001
Total Medical Expenses	**161,986,282**	**107,645,031**	**17,449,458**	**287,080,771**	**28,632,831**	**(2,608)**	**3,100,559**	**150,786**	**318,962,339**
Medical Loss Ratio	*93.6%*	*80.1%*	*84.3%*	*87.5%*	*93.1%*	*(4.3%)*	*86.2%*	*68.0%*	*87.9%*
GROSS MARGIN	**11,067,010**	**26,764,887**	**3,238,898**	**41,070,795**	**2,113,843**	**63,074**	**496,677**	**71,051**	**43,815,440**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				10,082,757	1,009,832		140,769	123,348	11,356,706
Non-Salary Operating Expenses				2,166,848	298,679	(4,253)	21,384	1,340	2,483,997
Depreciation & Amortization				841,208			1,086		842,294
Other Operating Expenses				1,689,555	59,199		7,235	123	1,756,111
Indirect Cost Allocation, Occupancy				(624,953)	948,600		14,660	7,530	345,837
Total Administrative Expenses				**14,155,415**	**2,316,309**	**(4,253)**	**185,134**	**132,341**	**16,784,946**
Administrative Loss Ratio				*4.3%*	*7.5%*	*(7.0%)*	*5.1%*	*59.7%*	*4.6%*
Operating Income/(Loss)				**26,915,380**	**(202,466)**	**67,327**	**311,543**	**(61,290)**	**27,030,494**
Investments and Other Non-Operating				(946,970)					13,296,361
CHANGE IN NET ASSETS				**$ 25,968,410**	**$ (202,466)**	**$ 67,327**	**$ 311,543**	**$ (61,290)**	**$ 40,326,855**
BUDGETED CHANGE IN NET ASSETS				6,895,101	(2,187,911)	-	96,068	(68,207)	6,785,668
Variance to Budget - Fav/(Unfav)				$ 19,073,310	$ 1,985,445	$ 67,327	$ 215,475	$ 6,917	$ 33,541,188

Back to Agenda

CalOptima Health

Unaudited Financial Statements as of July 31, 2023

MONTHLY RESULTS:

- Change in Net Assets is $40.3 million, $33.5 million favorable to budget
- Operating surplus is $27.0 million, with a surplus in non-operating income of $13.3 million

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

	July 2023		
Operating Income (Loss)	**Actual**	**Budget**	**Variance**
Medi-Cal	26.9	7.9	19.0
OneCare	(0.2)	(2.2)	2.0
OCC	0.1	0.0	0.1
PACE	0.3	0.1	0.2
MSSP	(0.1)	(0.1)	0.0
Total Operating Income (Loss)	**27.0**	**5.7**	**21.3**
Non-Operating Income (Loss)			
Net Investment Income/Expense	14.2	2.1	12.1
Net Rental Income/Expense	0.0	(0.0)	0.1
Grant Expense	(0.9)	(1.0)	0.1
Net QAF & IGT Income/Expense	0.0	0.0	0.0
Total Non-Operating Income/(Loss)	**13.3**	**1.0**	**12.2**
TOTAL	**40.3**	**6.8**	**33.5**

CalOptima Health - Consolidated
Enrollment Summary
For the One Month Ended July 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
142,819	142,604	215	0.2%	SPD	142,819	142,604	215	0.2%
301,907	319,348	(17,441)	(5.5%)	TANF Child	301,907	319,348	(17,441)	(5.5%)
142,582	134,693	7,889	5.9%	TANF Adult	142,582	134,693	7,889	5.9%
3,011	3,118	(107)	(3.4%)	LTC	3,011	3,118	(107)	(3.4%)
359,793	363,246	(3,453)	(1.0%)	MCE	359,793	363,246	(3,453)	(1.0%)
11,382	11,359	23	0.2%	WCM	11,382	11,359	23	0.2%
961,494	**974,368**	**(12,874)**	**(1.3%)**	**Medi-Cal Total**	**961,494**	**974,368**	**(12,874)**	**(1.3%)**
17,695	**17,601**	**94**	**0.5%**	**OneCare**	**17,695**	**17,601**	**94**	**0.5%**
		0	**0.0%**	**OneCare Connect**			**0**	**0.0%**
429	**453**	**(24)**	**(5.3%)**	**PACE**	**429**	**453**	**(24)**	**(5.3%)**
503	**568**	**(65)**	**(11.4%)**	**MSSP**	**503**	**568**	**(65)**	**(11.4%)**
979,618	**992,422**	**(12,804)**	**(1.3%)**	**CalOptima Total**	**979,618**	**992,422**	**(12,804)**	**(1.3%)**
				Enrollment (by Network)				
269,426	280,565	(11,139)	(4.0%)	HMO	269,426	280,565	(11,139)	(4.0%)
191,675	187,701	3,974	2.1%	PHC	191,675	187,701	3,974	2.1%
234,923	236,653	(1,730)	(0.7%)	Shared Risk Group	234,923	236,653	(1,730)	(0.7%)
265,470	269,449	(3,979)	(1.5%)	Fee for Service	265,470	269,449	(3,979)	(1.5%)
961,494	**974,368**	**(12,874)**	**(1.3%)**	**Medi-Cal Total**	**961,494**	**974,368**	**(12,874)**	**(1.3%)**
17,695	**17,601**	**94**	**0**	**OneCare**	**17,695**	**17,601**	**94**	**0**
0	**0**	**0**	**0.0%**	**OneCare Connect**	**0**	**0**	**0**	**0.0%**
429	**453**	**(24)**	**(5.3%)**	**PACE**	**429**	**453**	**(24)**	**(5.3%)**
503	**568**	**(65)**	**(11.4%)**	**MSSP**	**503**	**568**	**(65)**	**(11.4%)**
979,618	**992,422**	**(12,804)**	**(1.3%)**	**CalOptima Total**	**979,618**	**992,422**	**(12,804)**	**(1.3%)**

Note:* Total membership does not include MSSP

Back to Agenda

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2024

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD Actual	YTD Budget	Variance
HMOs															
SPD	14,267												14,267	14,224	43
TANF Child	69,607												69,607	79,706	(10,099)
TANF Adult	50,979												50,979	51,131	(152)
LTC													-		0
MCE	132,523												132,523	133,276	(753)
WCM	2,050												2,050	2,228	(178)
Total	**269,426**												**269,426**	**280,565**	**(11,139)**
PHCs															
SPD	4,581												4,581	4,458	123
TANF Child	147,946												147,946	149,642	(1,696)
TANF Adult	8,999												8,999	3,491	5,508
LTC													-		0
MCE	23,230												23,230	23,306	(76)
WCM	6,919												6,919	6,804	115
Total	**191,675**												**191,675**	**187,701**	**3,974**
Shared Risk Groups															
SPD	11,210												11,210	11,397	(187)
TANF Child	55,211												55,211	58,825	(3,614)
TANF Adult	43,118												43,118	40,436	2,682
LTC	1												1		1
MCE	124,149												124,149	124,745	(596)
WCM	1,234												1,234	1,250	(16)
Total	**234,923**												**234,923**	**236,653**	**(1,730)**
Fee for Service (Dual)															
SPD	99,242												99,242	99,173	69
TANF Child													-	2	(2)
TANF Adult	2,442												2,442	2,417	25
LTC	2,661												2,661	2,748	(87)
MCE	8,968												8,968	9,485	(517)
WCM	15												15	18	(3)
Total	**113,328**												**113,328**	**113,843**	**(515)**
Fee for Service (Non-Dual - Total)															
SPD	13,519												13,519	13,352	167
TANF Child	29,143												29,143	31,173	(2,030)
TANF Adult	37,044												37,044	37,218	(174)
LTC	349												349	370	(21)
MCE	70,923												70,923	72,434	(1,511)
WCM	1,164												1,164	1,059	105
Total	**152,142**												**152,142**	**155,606**	**(3,464)**
Grand Totals															
SPD	142,819												142,819	142,604	215
TANF Child	301,907												301,907	319,348	(17,441)
TANF Adult	142,582												142,582	134,693	7,889
LTC	3,011												3,011	3,118	(107)
MCE	359,793												359,793	363,246	(3,453)
WCM	11,382												11,382	11,359	23
Total MediCal M	**961,494**												**961,494**	**974,368**	**(12,874)**
OneCare	**17,695**												**17,695**	**17,601**	**94**
OneCare Connect													**-**		**0**
PACE	**429**												**429**	**453**	**(24)**
MSSP	**503**												**503**	**568**	**(65)**
Grand Total	**979,618**												**979,618**	**992,422**	**(12,804)**

Note:* Total membership does not include MSSP

Back to Agenda

ENROLLMENT:

Overall, July enrollment was 979,618

- Unfavorable to budget 12,804 or 1.3%
- Decreased 9,098 or 0.9% from Prior Month (PM) (June 2023)
- Increased 58,432 or 6.3% from Prior Year (PY) (July 2022)

Medi-Cal enrollment was 961,494

- Unfavorable to budget 12,874 or 1.3%
  - Temporary Assistance for Needy Families (TANF) unfavorable 9,552
  - Medi-Cal Expansion (MCE) unfavorable 3,453
  - Long-Term Care (LTC) unfavorable 107
  - Seniors and Persons with Disabilities (SPD) favorable 215
  - Whole Child Model (WCM) favorable 23
- Decreased 9,096 from PM

OneCare enrollment was 17,695

- Favorable to budget 94 or 0.5%
- Increased 8 from PM

PACE enrollment was 429

- Unfavorable to budget 24 or 5.3%
- Decreased 10 from PM

MSSP enrollment was 503

- Unfavorable to budget 65 or 11.4%
- Increased 5 from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the One Month Ending July 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
961,494	**974,368**	**(12,874)**	**(1.3%)**	**Member Months**	**961,494**	**974,308**	**(12,814)**	**(1.3%)**
				Revenues				
328,151,566	326,526,961	1,624,605	0.5%	Medi-Cal Capitation Revenue	328,151,566	326,526,961	1,624,605	0.5%
328,151,566	**326,526,961**	**1,624,605**	**0.5%**	**Total Operating Revenue**	**328,151,566**	**326,526,961**	**1,624,605**	**0.5%**
				Medical Expenses				
110,311,134	109,667,630	(643,504)	(0.6%)	Provider Capitation	110,311,134	109,667,630	(643,504)	(0.6%)
63,458,179	76,516,028	13,057,849	17.1%	Facilities Claims	63,458,179	76,516,028	13,057,849	17.1%
48,045,630	47,615,880	(429,750)	(0.9%)	Professional Claims	48,045,630	47,615,880	(429,750)	(0.9%)
44,571,043	52,045,636	7,474,593	14.4%	MLTSS	44,571,043	52,045,636	7,474,593	14.4%
(8,490)	-	8,490	100.0%	Prescription Drugs	(8,490)	-	8,490	100.0%
14,273,575	7,385,022	(6,888,553)	(93.3%)	Incentive Payments	14,273,575	7,385,022	(6,888,553)	(93.3%)
5,598,622	7,279,008	1,680,386	23.1%	Medical Management	5,598,622	7,279,008	1,680,386	23.1%
831,079	1,015,593	184,514	18.2%	Other Medical Expenses	831,079	1,015,593	184,514	18.2%
287,080,771	**301,524,797**	**14,444,026**	**4.8%**	**Total Medical Expenses**	**287,080,771**	**301,524,797**	**14,444,026**	**4.8%**
41,070,795	**25,002,164**	**16,068,631**	**64.3%**	**Gross Margin**	**41,070,795**	**25,002,164**	**16,068,631**	**64.3%**
				Administrative Expenses				
10,082,757	10,552,570	469,813	4.5%	Salaries, Wages & Employee Benefits	10,082,757	10,552,570	469,813	4.5%
472,044	965,803	493,759	51.1%	Professional Fees	472,044	965,803	493,759	51.1%
1,252,666	1,760,646	507,980	28.9%	Purchased Services	1,252,666	1,760,646	507,980	28.9%
442,138	483,310	41,172	8.5%	Printing & Postage	442,138	483,310	41,172	8.5%
841,208	400,000	(441,208)	(110.3%)	Depreciation & Amortization	841,208	400,000	(441,208)	(110.3%)
1,689,555	3,467,606	1,778,051	51.3%	Other Operating Expenses	1,689,555	3,467,606	1,778,051	51.3%
(624,953)	(526,091)	98,862	18.8%	Indirect Cost Allocation, Occupancy	(624,953)	(526,091)	98,862	18.8%
14,155,415	**17,103,844**	**2,948,429**	**17.2%**	**Total Administrative Expenses**	**14,155,415**	**17,103,844**	**2,948,429**	**17.2%**
				Non-Operating Income (Loss)				
(946,970)	(1,003,219)	56,250	5.6%	Grant Expense	(946,970)	(1,003,219)	56,250	5.6%
(946,970)	**(1,003,219)**	**56,250**	**5.6%**	**Total Non-Operating Income (Loss)**	**(946,970)**	**(1,003,219)**	**56,250**	**5.6%**
25,968,410	**6,895,101**	**19,073,310**	**276.6%**	**Change in Net Assets**	**25,968,410**	**6,895,101**	**19,073,310**	**276.6%**
87.5%	***92.3%***	***(4.9%)***		***Medical Loss Ratio***	***87.5%***	***92.3%***	***(4.9%)***	
4.3%	***5.2%***	***0.9%***		***Admin Loss Ratio***	***4.3%***	***5.2%***	***0.9%***	

Back to Agenda

MEDI-CAL INCOME STATEMENT– JULY MONTH:

REVENUES of $328.2 million are favorable to budget $1.6 million driven by:

- Unfavorable volume related variance of $4.3 million
- Favorable price related variance of $5.9 million
  - $5.8 million due to Student Behavioral Health Incentive Program (SBHIP)
  - $0.6 million of PY revenue due to retroactivity
  - Offset by:
    - $3.7 million from Proposition 56 and Enhanced Care Management (ECM) risk corridor

MEDICAL EXPENSES of $287.1 million are favorable to budget $14.4 million driven by:

- Favorable volume related variance of $4.0 million
- Favorable price related variance of $10.5 million
  - Facilities Claims expense favorable variance of $12.0 million due to low utilization
  - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $6.8 million due to lower than budgeted utilization
  - Medical Management expense favorable variance of $1.6 million
  - Offset by:
    - Incentive Payment expense unfavorable variance of $7.0 million due primarily to SBHIP
    - Provider Capitation expense unfavorable variance of $2.1 million
    - Professional Claims expense unfavorable variance of $1.1 million

ADMINISTRATIVE EXPENSES of $14.2 million are favorable to budget $2.9 million driven by:

- Other Non-Salary expense favorable to budget $2.5 million
- Salaries & Benefit expense favorable to budget $0.5

CHANGE IN NET ASSETS is $26.0 million, favorable to budget $19.1 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the One Month Ending July 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
17,695	**17,601**	**94**	**0.5%**	**Member Months**	**17,695**	**17,601**	**94**	**0.5%**
				Revenues				
22,505,569	22,780,185	(274,616)	(1.2%)	Medicare Part C Revenue	22,505,569	22,780,185	(274,616)	(1.2%)
8,241,105	8,672,534	(431,429)	(5.0%)	Medicare Part D Revenue	8,241,105	8,672,534	(431,429)	(5.0%)
30,746,673	**31,452,719**	**(706,046)**	**(2.2%)**	**Total Operating Revenue**	**30,746,673**	**31,452,719**	**(706,046)**	**(2.2%)**
				Medical Expenses				
12,394,220	13,048,854	654,634	5.0%	Provider Capitation	12,394,220	13,048,854	654,634	5.0%
6,071,235	5,168,359	(902,876)	(17.5%)	Inpatient	6,071,235	5,168,359	(902,876)	(17.5%)
1,311,939	1,461,035	149,096	10.2%	Ancillary	1,311,939	1,461,035	149,096	10.2%
81,791	81,142	(649)	(0.8%)	MLTSS	81,791	81,142	(649)	(0.8%)
7,809,050	9,667,680	1,858,630	19.2%	Prescription Drugs	7,809,050	9,667,680	1,858,630	19.2%
48,944	393,276	344,332	87.6%	Incentive Payments	48,944	393,276	344,332	87.6%
915,652	1,209,272	293,620	24.3%	Medical Management	915,652	1,209,272	293,620	24.3%
28,632,831	**31,029,618**	**2,396,787**	**7.7%**	**Total Medical Expenses**	**28,632,831**	**31,029,618**	**2,396,787**	**7.7%**
2,113,843	**423,101**	**1,690,742**	**399.6%**	**Gross Margin**	**2,113,843**	**423,101**	**1,690,742**	**399.6%**
				Administrative Expenses				
1,009,832	1,117,913	108,081	9.7%	Salaries, Wages & Employee Benefits	1,009,832	1,117,913	108,081	9.7%
48,440	75,000	26,560	35.4%	Professional Fees	48,440	75,000	26,560	35.4%
148,787	265,942	117,155	44.1%	Purchased Services	148,787	265,942	117,155	44.1%
101,452	125,704	24,252	19.3%	Printing & Postage	101,452	125,704	24,252	19.3%
59,199	77,870	18,672	24.0%	Other Operating Expenses	59,199	77,870	18,672	24.0%
948,600	948,583	(17)	(0.0%)	Indirect Cost Allocation, Occupancy	948,600	948,583	(17)	(0.0%)
2,316,309	**2,611,012**	**294,703**	**11.3%**	**Total Administrative Expenses**	**2,316,309**	**2,611,012**	**294,703**	**11.3%**
(202,466)	**(2,187,911)**	**1,985,445**	**90.7%**	**Change in Net Assets**	**(202,466)**	**(2,187,911)**	**1,985,445**	**90.7%**
93.1%	***98.7%***	***(5.5%)***		***Medical Loss Ratio***	***93.1%***	***98.7%***	***(5.5%)***	
7.5%	***8.3%***	***0.8%***		***Admin Loss Ratio***	***7.5%***	***8.3%***	***0.8%***	

Back to Agenda

ONECARE INCOME STATEMENT– JULY MONTH:

REVENUES of $30.7 million are unfavorable to budget $0.7 million driven by:

- Favorable volume related variance of $0.2 million
- Unfavorable price related variance of $0.9 million

MEDICAL EXPENSES of $28.6 million are favorable to budget $2.4 million driven by:

- Unfavorable volume related variance of $0.2 million
- Favorable price related variance of $2.6 million
  - Prescription Drugs expense favorable variance of $1.9 million
  - Provider Capitation expense favorable variance of $0.7 million
  - All other expenses net unfavorable variance of $0.1 million

ADMINISTRATIVE EXPENSES of $2.3 million are favorable to budget $0.3 million driven by:

- Other Non-Salary expense favorable to budget $0.2 million
- Salaries & Benefit expense favorable to budget $0.1 million

CHANGE IN NET ASSETS is ($0.2) million, favorable to budget $2.0 million

CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the One Month Ending July 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
-	-	-	0.0%	**Member Months**	-	-	-	0.0%
				Revenues				
6,644	-	6,644	100.0%	Medi-Cal Revenue	6,644	-	6,644	100.0%
53,822	-	53,822	100.0%	Medicare Part D Revenue	53,822	-	53,822	100.0%
60,466	**-**	**60,466**	**100.0%**	**Total Operating Revenue**	**60,466**	**-**	**60,466**	**100.0%**
				Medical Expenses				
(107,093)	-	107,093	100.0%	Facilities Claims	(107,093)	-	107,093	100.0%
76,097	-	(76,097)	(100.0%)	Ancillary	76,097	-	(76,097)	(100.0%)
(1,934)	-	1,934	100.0%	MLTSS	(1,934)	-	1,934	100.0%
(207)	-	207	100.0%	Prescription Drugs	(207)	-	207	100.0%
30,529	-	(30,529)	(100.0%)	Incentive Payments	30,529	-	(30,529)	(100.0%)
(2,608)	**-**	**2,608**	**100.0%**	**Total Medical Expenses**	**(2,608)**	**-**	**2,608**	**100.0%**
63,074	**-**	**63,074**	**100.0%**	**Gross Margin**	**63,074**	**-**	**63,074**	**100.0%**
				Administrative Expenses				
(4,253)	-	4,253	100.0%	Purchased Services	(4,253)	-	4,253	100.0%
(4,253)	**-**	**4,253**	**100.0%**	**Total Administrative Expenses**	**(4,253)**	**-**	**4,253**	**100.0%**
67,327	**-**	**67,327**	**100.0%**	**Change in Net Assets**	**67,327**	**-**	**67,327**	**100.0%**
(4.3%)	***0.0%***	***(4.3%)***		***Medical Loss Ratio***	***(4.3%)***	***0.0%***	***(4.3%)***	
(7.0%)	***0.0%***	***7.0%***		***Admin Loss Ratio***	***(7.0%)***	***0.0%***	***7.0%***	

Back to Agenda

CalOptima Health
PACE
Statement of Revenues and Expenses
For the One Month Ending July 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
429	**453**	(24)	(5.3%)	**Member Months**	**429**	**453**	**(24)**	**(5.3%)**
				Revenues				
2,795,256	2,938,329	(143,073)	(4.9%)	Medi-Cal Capitation Revenue	2,795,256	2,938,329	(143,073)	(4.9%)
558,782	733,443	(174,661)	(23.8%)	Medicare Part C Revenue	558,782	733,443	(174,661)	(23.8%)
243,198	206,900	36,298	17.5%	Medicare Part D Revenue	243,198	206,900	36,298	17.5%
3,597,237	**3,878,672**	**(281,435)**	**(7.3%)**	**Total Operating Revenue**	**3,597,237**	**3,878,672**	**(281,435)**	**(7.3%)**
				Medical Expenses				
1,105,789	1,122,828	17,039	1.5%	Medical Management	1,105,789	1,122,828	17,039	1.5%
778,790	885,248	106,458	12.0%	Facilities Claims	778,790	885,248	106,458	12.0%
608,595	835,024	226,429	27.1%	Professional Claims	608,595	835,024	226,429	27.1%
418,853	444,891	26,038	5.9%	Prescription Drugs	418,853	444,891	26,038	5.9%
(20,214)	118,034	138,248	117.1%	MLTSS	(20,214)	118,034	138,248	117.1%
208,748	184,024	(24,724)	(13.4%)	Patient Transportation	208,748	184,024	(24,724)	(13.4%)
3,100,559	**3,590,049**	**489,490**	**13.6%**	**Total Medical Expenses**	**3,100,559**	**3,590,049**	**489,490**	**13.6%**
496,677	**288,623**	**208,054**	**72.1%**	**Gross Margin**	**496,677**	**288,623**	**208,054**	**72.1%**
				Administrative Expenses				
140,769	150,448	9,679	6.4%	Salaries, Wages & Employee Benefits	140,769	150,448	9,679	6.4%
988	4,904	3,916	79.9%	Professional Fees	988	4,904	3,916	79.9%
20,396	8,290	(12,106)	(146.0%)	Purchased Services	20,396	8,290	(12,106)	(146.0%)
-	4,112	4,112	100.0%	Printing & Postage	-	4,112	4,112	100.0%
1,086	900	(186)	(20.7%)	Depreciation & Amortization	1,086	900	(186)	(20.7%)
7,235	9,039	1,804	20.0%	Other Operating Expenses	7,235	9,039	1,804	20.0%
14,660	14,862	202	1.4%	Indirect Cost Allocation, Occupancy	14,660	14,862	202	1.4%
185,134	**192,555**	**7,421**	**3.9%**	**Total Administrative Expenses**	**185,134**	**192,555**	**7,421**	**3.9%**
311,543	**96,068**	**215,475**	**224.3%**	**Change in Net Assets**	**311,543**	**96,068**	**215,475**	**224.3%**
86.2%	***92.6%***	***(6.4%)***		***Medical Loss Ratio***	***86.2%***	***92.6%***	***(6.4%)***	
5.1%	***5.0%***	***(0.2%)***		***Admin Loss Ratio***	***5.1%***	***5.0%***	***(0.2%)***	

Back to Agenda

CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the One Month Ending July 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
503	**568**	**(65)**	**(11.4%)**	**Member Months**	**503**	**568**	**(65)**	**(11.4%)**
				Revenues				
221,837	253,518	(31,681)	(12.5%)	Revenue	221,837	253,518	(31,681)	(12.5%)
221,837	**253,518**	**(31,681)**	**(12.5%)**	**Total Operating Revenue**	**221,837**	**253,518**	**(31,681)**	**(12.5%)**
				Medical Expenses				
135,811	184,712	48,901	26.5%	Medical Management	135,811	184,712	48,901	26.5%
14,975	32,957	17,982	54.6%	Waiver Services	14,975	32,957	17,982	54.6%
135,811	184,712	48,901	26.5%	Total Medical Management	135,811	184,712	48,901	26.5%
14,975	32,957	17,982	54.6%	Total Waiver Services	14,975	32,957	17,982	54.6%
150,786	**217,669**	**66,883**	**30.7%**	**Total Program Expenses**	**150,786**	**217,669**	**66,883**	**30.7%**
71,051	**35,849**	**35,202**	**98.2%**	**Gross Margin**	**71,051**	**35,849**	**35,202**	**98.2%**
				Administrative Expenses				
123,348	87,755	(35,593)	(40.6%)	Salaries, Wages & Employee Benefits	123,348	87,755	(35,593)	(40.6%)
1,333	1,333	(0)	(0.0%)	Professional Fees	1,333	1,333	(0)	(0.0%)
7	-	(7)	(100.0%)	Purchased Services	7	-	(7)	(100.0%)
123	7,443	7,320	98.3%	Other Operating Expenses	123	7,443	7,320	98.3%
7,530	7,525	(5)	(0.1%)	Indirect Cost Allocation, Occupancy	7,530	7,525	(5)	(0.1%)
132,341	**104,056**	**(28,285)**	**(27.2%)**	**Total Administrative Expenses**	**132,341**	**104,056**	**(28,285)**	**(27.2%)**
(61,290)	**(68,207)**	**6,917**	**10.1%**	**Change in Net Assets**	**(61,290)**	**(68,207)**	**6,917**	**10.1%**
68.0%	***85.9%***	***(17.9%)***		***Medical Loss Ratio***	***68.0%***	***85.9%***	***(17.9%)***	
59.7%	***41.0%***	***(18.6%)***		***Admin Loss Ratio***	***59.7%***	***41.0%***	***(18.6%)***	

Back to Agenda

CalOptima Health
Building 505 - City Parkway
Statement of Revenues and Expenses
For the One Month Ending July 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
43,405	21,873	(21,532)	(98.4%)	Purchased Services	43,405	21,873	(21,532)	(98.4%)
177,480	211,000	33,520	15.9%	Depreciation & Amortization	177,480	211,000	33,520	15.9%
22,758	34,000	11,242	33.1%	Insurance Expense	22,758	34,000	11,242	33.1%
114,584	167,302	52,719	31.5%	Repair & Maintenance	114,584	167,302	52,719	31.5%
51,715	57,859	6,144	10.6%	Other Operating Expenses	51,715	57,859	6,144	10.6%
(409,942)	(492,034)	(82,092)	(16.7%)	Indirect Cost Allocation, Occupancy	(409,942)	(492,034)	(82,092)	(16.7%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

Back to Agenda

CalOptima Health
Building 500 - City Parkway
Statement of Revenues and Expenses
For the One Month Ending July 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
162,485	133,810	28,675	21.4%	Rental Income	162,485	133,810	28,675	21.4%
162,485	**133,810**	**28,675**	**21.4%**	**Total Operating Revenue**	**162,485**	**133,810**	**28,675**	**21.4%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
13,362	7,126	(6,236)	(87.5%)	Purchased Services	13,362	7,126	(6,236)	(87.5%)
34,573	40,000	5,427	13.6%	Depreciation & Amortization	34,573	40,000	5,427	13.6%
7,500	10,091	2,591	25.7%	Insurance Expense	7,500	10,091	2,591	25.7%
37,467	84,860	47,393	55.8%	Repair & Maintenance	37,467	84,860	47,393	55.8%
44,022	24,446	(19,576)	(80.1%)	Other Operating Expenses	44,022	24,446	(19,576)	(80.1%)
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
136,925	**166,523**	**29,598**	**17.8%**	**Total Administrative Expenses**	**136,925**	**166,523**	**29,598**	**17.8%**
25,560	**(32,713)**	**58,273**	**178.1%**	**Change in Net Assets**	**25,560**	**(32,713)**	**58,273**	**178.1%**

Back to Agenda

OTHER INCOME STATEMENTS – JULY MONTH:

ONECARE CONNECT INCOME STATEMENT

CHANGE IN NET ASSETS is $67,327, favorable to budget $67,327 due to prior year activities

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.3 million favorable to budget $0.2 million

MSSP INCOME STATEMENT

CHANGE IN NET ASSETS is ($61,290), favorable to budget $6,917

BUILDING 500 INCOME STATEMENT

CHANGE IN NET ASSETS is $25,560, favorable to budget $58,273

- Net of $162,485 in rental income and $136,925 in expenses

INVESTMENT INCOME

- Favorable variance of $12.1 million due to $10.2 million favorable interest income and $1.9 million net realized and unrealized gain on investments

CalOptima Health
Balance Sheet
July 31, 2023

	July-23	June-23	$ Change	% Change
ASSETS				
Current Assets				
Cash and Cash Equivalents	551,847,227	771,575,961	(219,728,734)	(28.5%)
Short-term Investments	1,941,670,466	1,676,736,064	264,934,403	15.8%
Premiums due from State of CA and CMS	457,618,445	473,923,698	(16,305,253)	(3.4%)
Prepaid Expenses and Other	16,004,428	15,060,703	943,726	6.3%
Total Current Assets	**2,967,140,566**	**2,937,296,425**	**29,844,141**	**1.0%**
Board Designated Assets				
Cash and Cash Equivalents	(1,528,168)	1,940,210	(3,468,378)	(178.8%)
Investments	580,522,032	574,611,484	5,910,548	1.0%
Total Board Designated Assets	**578,993,864**	**576,551,694**	**2,442,170**	**0.4%**
Restricted Deposit	**300,000**	**300,000**	**-**	**0.0%**
Capital Assets, Net	**83,945,137**	**84,207,504**	**(262,367)**	**(0.3%)**
Total Assets	**3,630,379,567**	**3,598,355,623**	**32,023,944**	**0.9%**
Deferred Outflows of Resources				
Net Pension	24,373,350	24,373,350	-	0.0%
Other Postemployment Benefits	1,596,000	1,596,000	-	0.0%
Total Deferred Outflows of Resources	**25,969,350**	**25,969,350**	**-**	**0.0%**
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	**3,656,348,917**	**3,624,324,973**	**32,023,944**	**0.9%**
LIABILITIES				
Current Liabilities				
Medical Claims Liability	1,654,203,326	1,635,926,671	18,276,655	1.1%
Provider Capitation and Withholds	129,515,347	125,444,025	4,071,322	3.2%
Accrued Reinsurance Costs to Providers	4,978,758	4,312,093	666,666	15.5%
Unearned Revenue	36,931,649	63,442,911	(26,511,263)	(41.8%)
Accounts Payable and Other	15,219,697	15,081,943	137,753	0.9%
Accrued Payroll and Employee Benefits and Other	18,347,184	23,332,391	(4,985,207)	(21.4%)
Deferred Lease Obligations	52,156	55,308	(3,152)	(5.7%)
Total Current Liabilities	**1,859,248,117**	**1,867,595,343**	**(8,347,225)**	**(0.4%)**
GASB 96 Subscription Liabilities	16,107,717	16,107,717	-	0.0%
Postemployment Health Care Plan	19,019,314	18,975,000	44,314	0.2%
Net Pension Liability	40,465,145	40,465,145	-	0.0%
Total Liabilities	**1,934,840,293**	**1,943,143,204**	**(8,302,911)**	**(0.4%)**
Deferred Inflows of Resources				
Net Pension	3,387,516	3,387,516	-	0.0%
Other Postemployment Benefits	7,788,000	7,788,000	-	0.0%
Total Deferred Inflows of Resources	**11,175,516**	**11,175,516**	**-**	**0.0%**
Net Position				
Required TNE	108,222,485	107,969,096	253,389	0.2%
Funds in excess of TNE	1,602,110,624	1,562,037,157	40,073,466	2.6%
Total Net Position	**1,710,333,109**	**1,670,006,253**	**40,326,855**	**2.4%**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION	**3,656,348,917**	**3,624,324,973**	**32,023,944**	**0.9%**

Back to Agenda

BALANCE SHEET – JULY MONTH:

ASSETS of $3.7 billion increased $32.0 million from June or 0.9%

- Operating Cash and Short-term Investments net increase of $45.2 million due to a CalAIM receipt and one less Facets check run
- Premiums due from State and the Centers for Medicare & Medicaid Services (CMS) decrease of $16.3 million is due to an $11.1 million risk adjustment for the OneCare Mid-year pharmacy Hierarchical Condition Category (HCC), along with variable timing of capitation payments
- Cash and Cash Equivalents for Board-Designated Assets reflects a cash deficit of $1.5 million due to the timing of trade settlement date

LIABILITIES of $1.9 billion decreased $8.3 million from June or 0.4%

- Unearned Revenue decreased $26.5 million due to timing of capitation payments from CMS
- Medical Claims Liability increased $18.3 million due to timing of claim payments

NET ASSETS of $1.7 billion, increased $40.3 million from June or 2.4%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of July 31, 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	236,057,900				
	Tier 1 - MetLife	234,132,545				
Board Designated Reserve		470,190,445	348,679,779	544,495,035	121,510,666	(74,304,591)
	Tier 2 - Payden & Rygel	54,552,450				
	Tier 2 - MetLife	54,250,970				
TNE Requirement		108,803,419	108,222,485	108,222,485	580,934	580,934
	Consolidated:	**578,993,864**	**456,902,264**	**652,717,520**	**122,091,600**	**(73,723,656)**
	Current reserve level	*1.77*	*1.40*	*2.00*		

Back to Agenda

CalOptima Health
Statement of Cash Flows
July 31, 2023

	Month to Date
CASH FLOWS FROM OPERATING ACTIVITIES:	
Change in net assets	40,326,855
Adjustments to reconcile change in net assets	
to net cash provided by operating activities	
Depreciation & Amortization	1,054,347
Changes in assets and liabilities:	
Prepaid expenses and other	(943,726)
Catastrophic reserves	
Capitation receivable	16,305,253
Medical claims liability	18,943,320
Deferred revenue	(26,511,263)
Payable to health networks	4,071,322
Accounts payable	137,753
Accrued payroll	(4,940,893)
Other accrued liabilities	(3,152)
Net cash provided by/(used in) operating activities	48,439,819
GASB 68 and GASB 75 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	(264,934,403)
Change in Property and Equipment	(791,980)
Change in Restricted Deposit & Other	-
Change in Board Designated Reserve	(2,442,170)
Change in Homeless Health Reserve	-
Net cash provided by/(used in) investing activities	(268,168,553)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(219,728,734)
CASH AND CASH EQUIVALENTS, beginning of period	$771,575,961
CASH AND CASH EQUIVALENTS, end of period	**551,847,227**

Back to Agenda

CalOptima Health - Consolidated
Net Assets Analysis
For the One Month Ended July 31, 2023

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 7/31/2023	**$1,710.3**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**579.0**			**33.9%**
	Capital Assets, net of Depreciation[2]	**83.9**			**4.9%**
Resources Allocated[3]	Homeless Health Initiative[4]	$21.0	$59.9	$38.9	1.2%
	Housing and Homelessness Incentive Program[5]	69.7	97.2	27.5	4.1%
	Intergovernmental Transfers (IGT)	58.7	111.7	53.0	3.4%
	Digital Transformation and Workplace Modernization	98.5	100.0	1.5	5.8%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	Outreach Strategy for CalFresh, Redetermination support, and other programs	6.9	8.0	1.1	0.4%
	Coalition of Orange County Community Health Centers Grant	40.0	50.0	10.0	2.3%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	1.0	1.0	0.0	0.1%
	General Awareness Campaign	1.0	2.7	1.7	0.1%
	Member Health Needs Assessment	1.0	1.0	0.0	0.1%
	Five-Year Hospital Quality Program Beginning MY 2023	151.7	153.5	1.8	8.9%
	Medi-Cal Annual Wellness Initiative	2.4	3.8	1.4	0.1%
	Skilled Nursing Facility Access Program	9.7	10.0	0.3	0.6%
	In-Home Care Pilot Program with the UCI Family Health Center	1.4	2.0	0.6	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	4.5	5.0	0.5	0.3%
	Community Living and PACE Center in the City of Tustin	17.7	18.0	0.3	1.0%
	Stipend Program for Master of Social Works	5.0	5.0	0.0	0.3%
	Wellness & Prevention Program	2.7	2.7	0.0	0.2%
	CalOptima Health Provider Workforce Development Fund	50.0	50.0	0.0	2.9%
	Post-Pandemic Supplemental	107.5	107.5	0.0	6.3%
	Subtotal:	**$650.4**	**$805.0**	**$154.6**	**38.0%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$397.0**			**23.2%**

[1] Total of Board Designated Reserve and unallocated reserve amount can support approximately 90 days of CalOptima Health's current operations

[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements

[3] Initiatives that have been paid in full in the previous year are omitted from the list of Resources Allocated

[4] See HHI summary and Allocated Funds for list of Board approved initiatives

[5] On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP (see HHIP Summary)

Back to Agenda

CalOptima Health
Key Financial Indicators
As of July 31, 2023

	Item Name	Month-to-Date (Jul 2023)					FY 2024 Year-to-Date (Jul 2023)				
		Actual	Budget	Variance	%		Actual	Budget	Variance	%	
Income Statement	*Member Months*	979,618	992,422	(12,804)	(1.3%)		979,618	992,422	(12,804)	(1.3%)	
	*Operating Revenue **	362,777,779	362,111,870	665,909	0.2%		362,777,779	362,111,870	665,909	0.2%	
	*Medical Expenses **	318,962,339	336,362,133	17,399,794	5.2%		318,962,339	336,362,133	17,399,794	5.2%	
	General and Administrative Expense	16,784,946	20,011,467	3,226,521	16.1%		16,784,946	20,011,467	3,226,521	16.1%	
	Non-Operating Income/(Loss)	13,296,361	1,047,398	12,248,964	(1169.5%)		13,296,361	1,047,398	12,248,964	(1169.5%)	
	Summary of Income & Expenses	40,326,855	6,785,668	33,541,188	494.3%		40,326,855	6,785,668	33,541,188	494.3%	
Ratios	Medical Loss Ratio (MLR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	87.9%	92.9%	(5.0%)			87.9%	92.9%	(5.0%)		
	Administrative Loss Ratio (ALR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	4.6%	5.5%	0.9%			4.6%	5.5%	0.9%		

Key:

> 0%	
> -20%, < 0%	
< -20%	

	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
Investment	*@7/31/2023*	2,506,471,438	2,235,945,330	270,526,108	12.1%

Unallocated/Unassigned Reserve Balance	Current Month @ July 2023	Fiscal Year Ending June 2022	Change	%
Consolidated	396,975,204	354,771,258	42,203,946	11.9%
*Days Cash On Hand***	90			

**Total of Board Designated Reserve and unallocated reserve amount can support approximatley 91 days of CalOptima Health's current operations.

Back to Agenda

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the One Months Ended July 31, 2023

	FY 2024 Month-to-Date				FY 2024 Year-to-Date			
	Actual Spend	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**
Capital Assets (Cost, Information Only):								
Total Capital Assets	**127,096**	**4,819,310**	**4,692,214**	**97.4%**	**127,096**	**4,819,310**	**4,692,214**	**97.4%**
Operating Expenses:								
Salaries, Wages & Benefits	584,454	609,649	25,195	4.1%	584,454	609,649	25,195	4.1%
Professional Fees	9,712	175,416	165,704	94.5%	9,712	175,416	165,704	94.5%
Purchased Services	-	155,000	155,000	100.0%	-	155,000	155,000	100.0%
Depreciation Expenses	242,035	-	(242,035)	0.0%	242,035	-	(242,035)	0.0%
Other Expenses	549,052	1,278,509	729,457	57.1%	549,052	1,278,509	729,457	57.1%
Total Operating Expenses	**1,385,253**	**2,218,574**	**833,321**	**37.6%**	**1,385,253**	**2,218,574**	**833,321**	**37.6%**

Funding Balance Tracking:	**Actual Spend**	**Approved Budget**
Beginning Funding Balance	100,000,000	100,000,000
Less:		
FY2023-24	11,979,062	47,973,113
FY2024-25	1,512,349	26,622,899
FY2025-26		
Ending Funding Balance	**86,508,589**	**25,403,988**

Back to Agenda

CalOptima Health

Summary of Homeless Health Initiatives (HHI) and Allocated Funds

As of July 31, 2023

Funds Allocation, approved initiatives:	**Allocated Amount**	**Utilized Amount**	**Remaining Approved Amount**
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Days, HCAP and FQHC Administrative Support	963,261	662,709	300,552
FQHC (Community Health Center) Expansion	21,902	21,902	-
Homeless Clinical Access Program (HCAP) and CalOptima Days	9,888,914	3,170,400	6,718,514
Vaccination Intervention and Member Incentive Strategy	400,000	54,649	345,351
Street Medicine	8,000,000	1,455,500	6,544,500
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[1]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$ 100,000,000**	**$ 38,947,561**	**$ 61,052,439**
Transfer of funds to HHIP[1]	(40,100,000)	-	(40,100,000)
Program Total	**$ 59,900,000**	**$ 38,947,561**	**$ 20,952,439**

Notes:

[1]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP.

CalOptima Health

Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds

As of July 31, 2023

Funds Allocation, approved initiatives:	**Allocated Amount**	**Utilized Amount**	**Remaining Approved Amount**
Office of Care Coordination	2,200,000	2,200,000	-
Pulse For Good	800,000	15,000	785,000
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	1,461,149	2,560,162
Infrastructure Projects	5,832,314	2,785,365	3,046,949
Capital Projects	73,247,369	21,000,000	52,247,369
System Change Projects	10,180,000	-	10,180,000
Non-Profit Healthcare Academy	354,530	-	354,530
Total of Approved Initiatives	**$ 97,235,524** [1]	**$ 27,461,514**	**$ 69,774,010**

Notes:

[1]Total funding $97.2M: $40.1M Board-approved reallocation from HHI, $22.3M from CalOptima Health existing reserves and $34.8M from DHCS HHIP incentive payments

CalOptima Health
Budget Allocation Changes
Reporting Changes for July 2023

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	Purchased Services - TB Shots, Flu Shots, COVID Related Services & COVID Cleaning/Building Sanitization	Moving Services	$40,000	To repurpose from TB/Flu Shots and COVID Cleaning to provide more funding for Moving Services. ($16,000 from TB Shots, Flu Shots, COVID related services, $24,000 from COVID Cleaning/Building Sanitization)	2023-2024
July	Medi-Cal	DTS Capital: I&O Internet Bandwidth	DTS Capital: I&O Network Bandwidth	$36,000	To reallocate funds from I&O Internet Bandwidth to I&O Network Bandwidth to cover shortage of fund for RFP.	2023-2024
July	OneCare	Communication - Professional Fees Marketing/Advertising Agency Consulting	Community Relations - Membership Fees	$60,000	To reallocate funds from Communication – Professional Fees Marketing/Advertising Agency Consulting to Community Relations – Membership Fees to help fund E-Indicator Sponsorship bi-weekly newsletter.	2023-2024
July	Medi-Cal	Corporate Application HR - Dayforce In-View	Corporate Application HR - SilkRoad OpenHire and Wingspan	$23,000	To reallocate funds from Corporate Application HR - Dayforce Inview to Corporate Application HR-SilkRoad OpenHire and Wingspan due to short of funds for renewal of contract.	2023-2024

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $250,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Back to Agenda

Board of Directors Meeting
September 7, 2023

Monthly Compliance Report

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

A. Updates on Regulatory Audits

1. OneCare (OC)/ PACE

- **2021 Centers for Medicare & Medicaid Services (CMS) Program Audit/Independent Validation Audit (IVA)/2023 Revalidation Audit *(applicable to OC and OCC)*:**

  - The 2021 Program Audit is closed.
  - CMS notified CalOptima Health on August 15th that CMS has determined CalOptima Health sufficiently corrected the audit findings.

- **2023 DHCS PACE Audit *(applicable to PACE)*:**

  - The 2023 DHCS PACE audit is closed.
  - On July 24, 2023, DHCS accepted the CAP response submitted by CalOptima Health on June 23, 2023.
    - No further action is required as this concludes the DHCS PACE Audit.

- **2023 OneCare CPE Audit**

  - CalOptima Health is required to conduct an independent audit on the effectiveness of its Compliance program on an annual basis.
  - CalOptima Health engaged an independent consultant to conduct the audit to ensure that its Compliance Program is administering the elements of an effective compliance program as outlined in the CMS Medicare Parts C and D Program Audit Protocols.
  - The audit will start in early August and continue through November 2023.
  - The audit review period: 2/1/23-8/1/23.

Back to Agenda

2. Medi-Cal

- **2024 Managed Care Plan (MCP) Operational Readiness Contract:**

  Update:

  As of August 1, 2023:
  - **197 deliverables have been submitted** for 2024 MCP operational readiness.
  - **187 items have received approval** at this point.
    - Remaining deliverables are awaiting a response from the Department of Health Care Services (DHCS) or under review by CalOptima Health as part of an additional information request made by DHCS.

  On-track for all remaining deliverables.

  Background – FYI Only

  Throughout CY 2022 and CY 2023, MCPs, including CalOptima Health will be required to submit a series of contract readiness deliverables to DHCS for review and approval. Staff will implement the broad operational changes and contractual requirements outlined in the Operational Readiness agreement to ensure compliance with all requirements by January 1, 2024, contract effective date.

- **2023 DHCS Routine Medical Audit:**

  ***Update**:* On 7/27/23, CalOptima Health provided its response to the DHCS draft findings report. In its response, CalOptima Health did not rebut the findings but rather sought to ensure the accuracy of statements within the report.

  DHCS will consider CalOptima Health's feedback and issue a final report and formal corrective action plan request in August 2023.

  - There were two findings in the draft report. Mitigation and resolution efforts are underway as is documentation of corrective action, in anticipation of a formal corrective action request.

  Background – FYI Only
  On 7/5/23, CalOptima Health received the draft findings report for the 2023 DHCS Medical Audit. DHCS' draft findings report identified **two (2) findings**; this is an improvement from the 2022 DHCS Medical Audit which resulted in nine (9) total findings.

  Below is a summary of the draft findings and identified next steps:
  - Category breakdown and findings are as follows:
    - Category 1 Utilization Management (UM) – **No Findings**
    - Category 2 Case Management and Coordination of Care – **2 Findings**
    - Category 3 Access and Availability of Care – **No Findings**
    - Category 4 Members' Rights – **No Findings**
    - Category 5 Quality Management – **No Findings**

Back to Agenda

- Category 6 Administrative and Organizational Capacity – **No Findings**

The summary of the draft findings in Category 2 are as follows:

- **2.1.1 Provision of Initial Health Assessment (IHA)**
  DHCS Finding #1: The Plan did not ensure that an IHA was performed by the member's primary care providers, perinatal care providers, and non-physician mid-level practitioners.
  - DHCS Recommendation: Revise and implement policies and procedures to ensure compliance and the provision of the Plan's contracted PCPs to perform IHA to new members.
- **2.2.1 - Performance of Pediatric Risk Stratification Process (PRSP)**
  DHCS Finding #2: The Plan did not ensure that members who did not have medical utilization data, claims processing data history, or other assessments or survey information available for PRSP were automatically categorized as high risk until further assessment data was gathered to make an additional risk determination.
  - DHCS Recommendation: Revise and implement policies and procedures to ensure compliance with PRSP performance to WCM members.

- **NEXT STEPS**
  Dates are subject to change based on DHCS timeline.
  - **Final Report & CAP**: DHCS is expected to finalize its report and formally request a Corrective Action Plan (CAP) from CalOptima Health in August 2023.
  - **CAP Response**: Medi-Cal Regulatory Affairs and Compliance (RAC) anticipates that CalOptima Health will have thirty (30) calendar days from date of receipt, to respond to the CAP request.
    - ***CalOptima Health staff notes that mitigation and resolution efforts are underway as is documentation of corrective action, in anticipation of a formal corrective action request***.

Annual (routine) Audit Scope:
- Utilization management
- Case management and coordination of care
- Availability and accessibility
- Member rights
- Quality management
- Administrative and organizational capacity

Focused Audit:
- Scope included:
  - Transportation
  - Behavioral Health
- Staff interviews were conducted February 27 through March 8, 2023.
- No soft exit.
- Once DHCS concludes its focused audit reviews of all MCPs, a report is anticipated to be released by Q2 2024. More information to follow as DHCS finalizes and communicates next steps.

- **2021 DHCS Medical Audit:**

  Update:
  - The audit is closed.
  - On 8/10/23, DHCS notified CalOptima Health that all CAP responses have been accepted and the audit is closed. CalOptima Health is awaiting feedback or status update based on submissions.

B. Regulatory Notices of Non-Compliance

- CalOptima Health did not receive any notices of non-compliance from its regulators for the month of July 2023.

C. Updates on Health Network Monitoring and Audits

- **Health Network Audits:**

  - CalOptima Health's Delegation Oversight (DO) department completed annual audits on the following delegated health networks to assess their capabilities and performance with delegated activities:

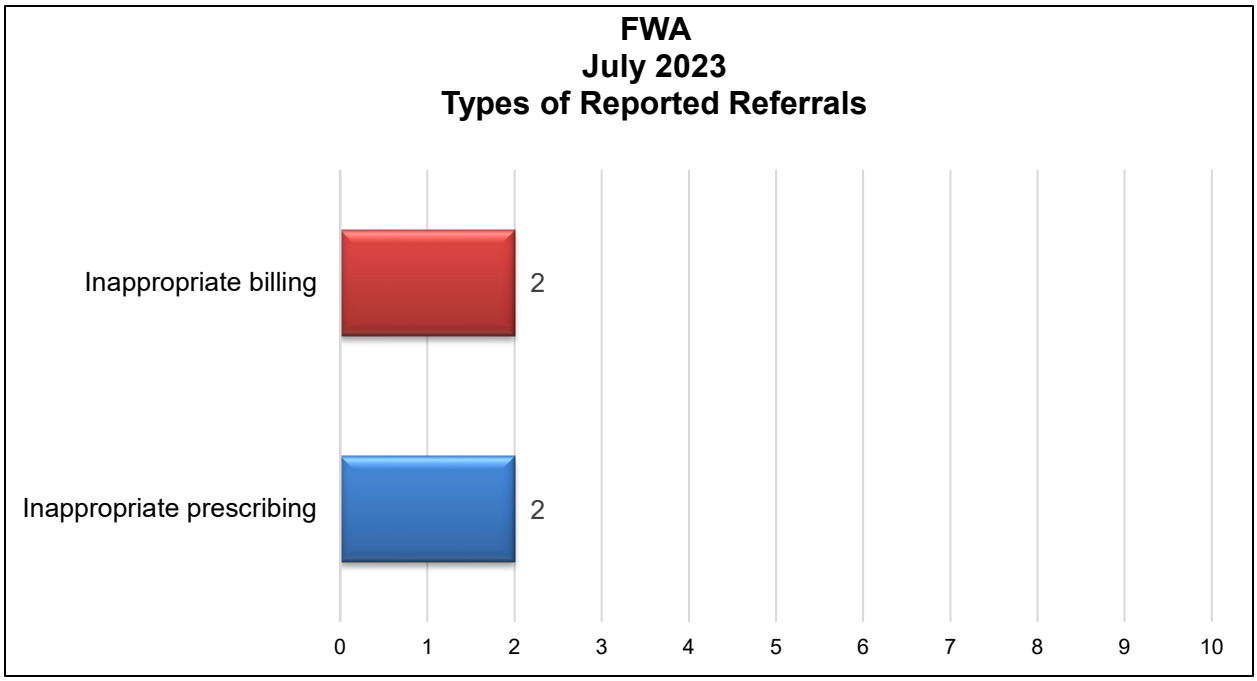
    - AMVI Care Health Network, May 1, 2022, to March 31, 2023
    - Prospect Medical Group, May 1, 2022, to March 31, 2023
    - United Care Medical Group, May 1, 2022, to March 31, 2023

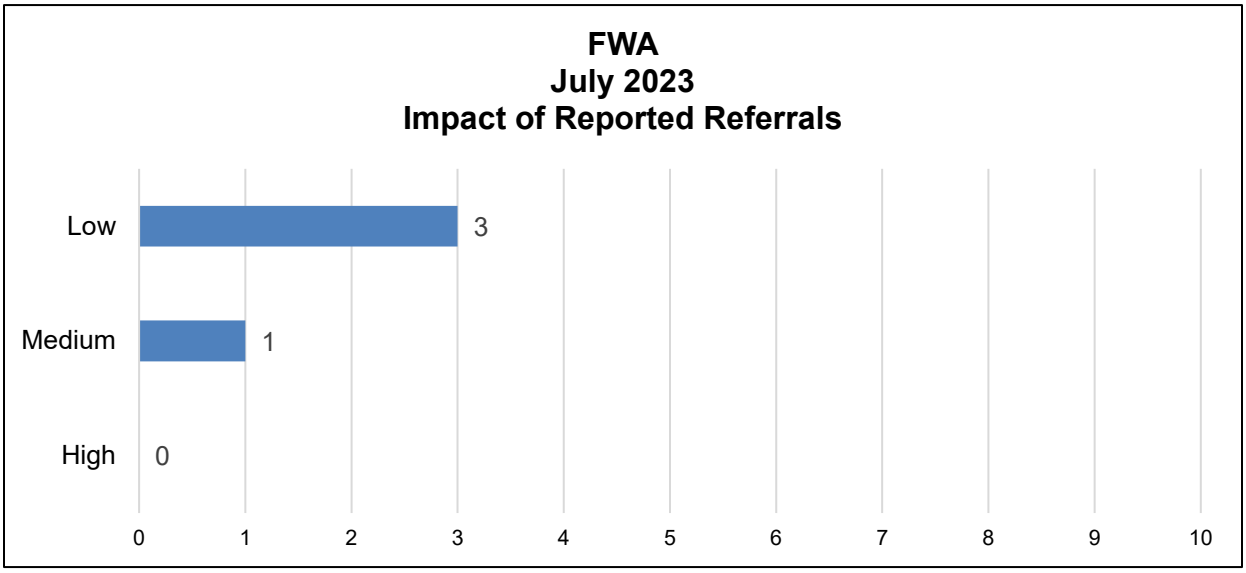
  - Audit tools and elements were derived from accrediting, regulatory and CalOptima Health contractual standards. For areas that scored below the 100% threshold, DO issued a corrective action plan (CAP) request and is actively working with each health network to remediate findings.
  - The audit included review of specific P&Ps and sample files.
  - A number of areas were identified as opportunities to improve processes and timeliness of notifications to achieve 100% compliance.
  - CalOptima Health will validate the effectiveness of corrective actions once implementation is complete.

D. Internal Audit Updates

- Customer Service Department (Medi-Cal) - CAPs management
- PACE (Alternative Care Setting) – CAPs management
- Grievance and Appeals Resolution (OneCare) – Audit engaged
- Utilization Management – Audit engaged

E. Fraud, Waste & Abuse (FWA) Investigations (July 2023)

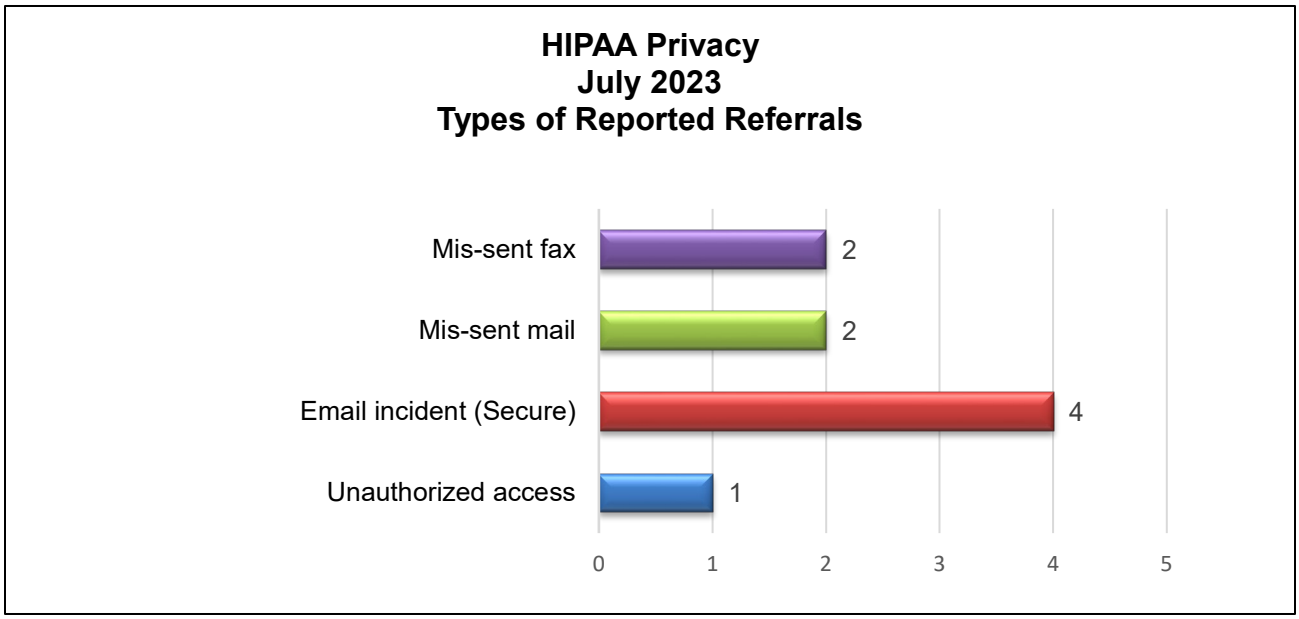


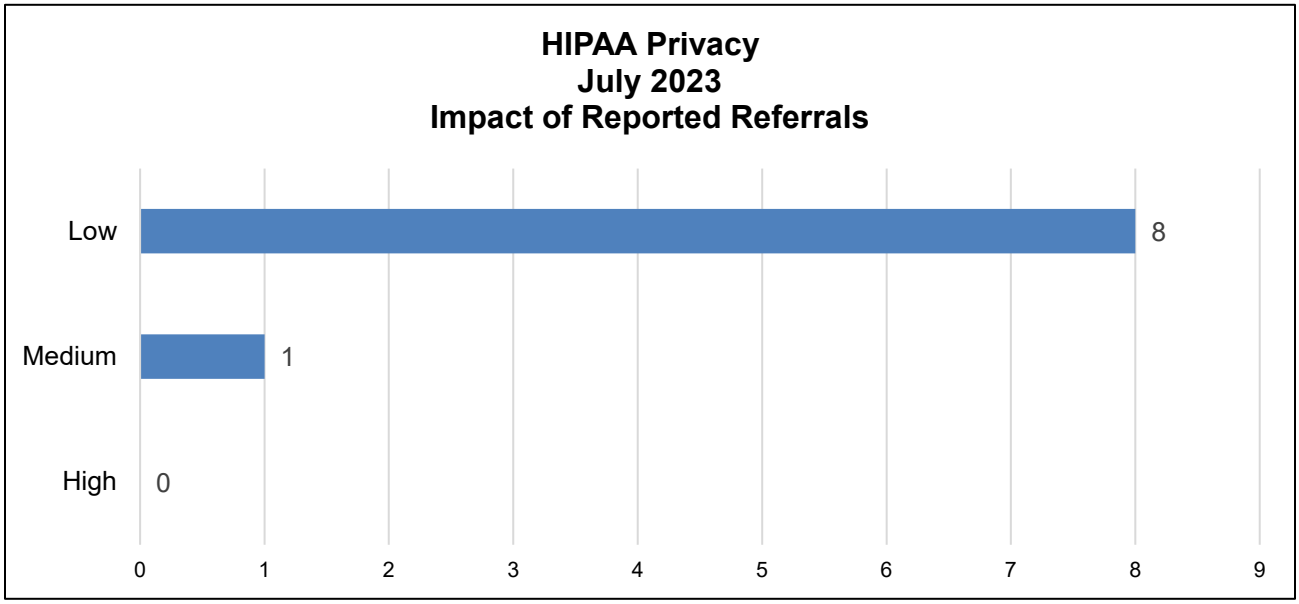


Total Number of New Cases Referred to DHCS (State)	4
Total Number of New Cases Referred to DHCS and CMS*	1
Total Number of Referrals (Subjects) Reported to Regulatory Agencies	**4**

* Any potential FWA *with impact to Medicare* is reported to CMS within 30 days of the start of an investigation.

F. Privacy Update: (July 2023)





PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	9
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

NOTABLE PRIVACY/SECURITY EVENT

On August 3, 2023, CalOptima Health was made aware of a security event at Prospect Medical Systems ("PMS"), whose Medical Service Organization function includes Prospect Medical Group, AMVI, and United Care Medical Group. PMS reported this a cybersecurity event and has employed a cybersecurity investigative firm. The investigation and remediation efforts are ongoing. CalOptima Health has taken the following actions:

- CalOptima Health ITS Security immediately stopped email transmissions and SFTP communications, and initiated its ransomware playbook procedures to prevent any cross contamination between our organizations so that CalOptima Health's network and systems are not affected.
- The event was reported to CalOptima Health's CMS and DHCS contract managers.
- CalOptima Health continues to work with PMS to ensure members that are assigned to the PMS network receive continuity of care and are monitoring incoming calls to assist PMS members as needed.
- To date, no data exfiltration has been identified by PMS.

POTOMAC PARTNERS DC

STRATEGIC HEALTH CARE

MEMORANDUM

August 11, 2023

To: CalOptima Health

From: Potomac Partners DC & Strategic Health Care

Re: August Board of Directors Report

AUGUST RECESS

The House and Senate are in recess for the entire month of August. The Senate will return to session on September 5th. The House will return to session on September 12th.

FISCAL YEAR 2024 APPROPRIATIONS

By the start of the August recess period, the House had passed one of the twelve Fiscal Year 2024 (FY24) appropriations bills on the House floor — the Military Construction-Veterans Affairs (MilCon-VA) bill. The Senate has passed none of their FY24 appropriations bills on the floor.

Despite progress on less controversial bills, the House Appropriations Committee has yet to complete a full committee markup of the Labor-Health and Human Services-Education (LHHSE) bill. The House did hold a subcommittee markup of the FY24 Labor-HHS-Education bill. The text of the draft House bill is available here. Still, the committee report and any major amendments will not be available until after the full committee markup, which will now take place in September at the earliest. A Republican summary of the bill is also available here. The initial House LHHSE bill is 60.3 billion (29%) below the FY23 enacted spending level. The HHS portion is $14 billion (12%) below the FY23 enacted level. It includes provisions that would eliminate Title X Family Planning grants, reduce funding for the CDC by $1.6 billion (18%), but maintain funding for substance abuse, mental health, and opioid response. The House bill is still in the draft phase and could, although unlikely, see significant changes in the full committee markup.

The Senate Appropriations Committee approved their LHHSE bill on July 27th by a vote of 26-2. The bill provides $117 for HHS, a $300 million decrease compared to FY23 enacted levels. It also provides over $5 billion for opioid treatment and prevention, a more than $125 million increase compared to FY23. The draft Senate LHHSE bill is available here, along with a summary here, and the committee report here.

Back to Agenda

Congress will only have 12 legislative days to pass all twelve appropriations bills before Fiscal Year 2023 ends at midnight on September 30, 2023. As a result, House and Senate appropriators anticipate that a Continuing Resolution (CR) will be necessary to fund the government. Notably, the new Debt Limit included provisions that will trigger an automatic across-the-board 1% cut of all federal spending if Congress relies on a CR extension. It remains to be seen if Congress will choose to override the automatic cut, or exempt certain programs.

House Energy & Commerce Committee Bill Markups

The House Energy and Commerce Committee passed numerous health-related bills last month. Bills passed include: Permanently allowing employers to offer telehealth as a tax-free benefit separate from their group health insurance plans (H.R. 824), reauthorizing the Prematurity Research Expansion and Education for Mothers Who Deliver Infants Early Act (H.R. 3226), and reauthorizing federal support for states to address disparities in maternal health outcomes (H.R. 3838). H.R. 4420 and H.R. 4412 were also passed to reauthorize health care preparedness and response programs, among others. The full markup is available for viewing here. The legislation and amendments that passed the Health Subcommittee are available here.

The Senate Health, Education, Labor, and Pensions Committee also advanced its version of the health care preparedness and response legislation — S.2333, Pandemic and All-Hazards Preparedness and Response Act. The markup is available for viewing here.

CMS Proposes Behavioral Health Expansions

CMS has proposed expanding Medicare access to behavioral health services with a new rule. The recent Outpatient Prospective Payment System (OPPS) rule contained a proposal to pay for intensive outpatient treatment for seniors seeking mental and behavioral services, something that many state Medicaid plans and private insurers already cover. For a long time, advocates have called this an inequity for the older population who benefit from staying in their own homes at night while receiving services during the day from an outpatient program. The proposal is expected to add over 200,000 mental health clinicians to the Medicare workforce. A CMS summary is available here. The proposed rule is available here.

California and Kentucky also received approval from CMS for community-based mobile crisis intervention teams to provide Medicaid crisis services. The full announcement is available here. The California approval is available here.

HHS Inspector General Report on Denials of Care

The Office of the Inspector General (OIG) for the Department of Health and Human Services (HHS) has released a report stating that Medicaid Managed Care Organizations (MCOs) have denied millions of requests for care. The OIG also highlighted concerns about lump sum payments made per patient, stating that the payment structure could incentivize plans to deny care to maximize profits. The full OIG report is available here.

EDELSTEIN GILBERT ROBSON & SMITH LLC

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

August 28, 2023

CalOptima Health
LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

General Update

The Legislature is approaching the end of session, with two major deadlines slated for the last three weeks before session adjourns on September 14.

The fiscal committee deadline is this Friday, September 1, where the Assembly and Senate Appropriations Committees will dispense with all the bills on the Suspense File. At this hearing, bills will be held, made two-year bills, passed as is, or passed with amendments, typically to reduce the fiscal impact of the bill. It remains to be seen if the state's budget outlook will impact the number of bills that make it out of this key committee hearing.

After the fiscal committee deadline, Legislators will have two weeks of floor session to pass bills off the floor of the second house, and if needed, the floor of the house of origin for concurrence, before the Legislature adjourns.

The Governor will then have a month to consider the bills that were placed on his desk at the end of session. The Legislature will remain on recess until 2024, reconvening on January 3.

Budget Update

As discussed in previous reports, the Governor signed the budget agreement in July which included a Budget Bill Jr. and various trailer bills. Before the end of session, the Legislature intends to consider a secondary budget package that consists of additional trailer bills and another Budget Bill Jr. Four bills went into print on Sunday, which we are in the process of reviewing. It is anticipated that the bills will be taken up relatively quickly. Further budget bills could go into print in the coming days.

Legislation of Interest

AB 271 (Quirk-Silva) - Homeless Death Review Committee. This bill would allow counties to establish a homeless death review committee to gather information to identify the root causes of death of homeless individuals as well as determine strategies to improve the coordination of services for this population.

This bill passed out of the Legislature on August 14 and is on the Governor's desk for his consideration.

CalOptima Health supports this bill.

AB 1230 (Valencia) - Special Needs Plans. This measure directs the Department of Health Care Services to offer contracts to health care service plans for Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) to provide care to dual eligible beneficiaries. Most County Organized Health Systems have expressed concerns with this bill because it circumvents COHS authority to exclusively contract with providers in their services areas.

This bill is a two-year bill.

SB 598 (Skinner) - Prior Authorization. This bill would prohibit insurance plans from requiring contracted physicians and other health professionals to get prior authorization for any covered services if the plan approved or would have approved no less than 90% of prior authorization requests in the last one-year contract period. Amendments accepted in May encourage providers and plans towards a 2018 agreement to improve prior authorization.

The commercial health plans and the Local Health Plans of California (LHPC) are opposing SB 598.

This bill is pending on the Assembly Appropriations Committee Suspense File.

Mental Health

Most of the big health-related bills still pending in the Legislature focus on mental health reforms. SB 43 by Senator Eggman, which would change the definition of "gravely disabled" to include drug and alcohol addiction, will likely pass out of the Assembly Appropriations Committee this Friday. If passed into law, it will make it easier to place homeless people under Conservatorship.

AB 531 by Assemblymember Irwin would place the $4.6 billion Behavioral Health Infrastructure Bond Act on the March 2024 ballot. Funding from this bond would be used to build mental health treatment facilities needed to address California's large homeless population. AB 531 is pending in the Senate Appropriations Committee.

Finally, SB 326 by Senator Eggman would reprioritize funding in the Behavioral Health Services Act by redirecting some of the money to more directly treat homelessness. Funding in the Act is derived from the "millionaires' tax" adopted by voters in 2004 with the passage of Proposition 62. This bill is controversial because some county programs and non-profits will lose funding, while others will receive new funding. Despite the

Back to Agenda

controversy, we expect this measure to pass the Legislature and appear on the March 2024 ballot.

Back to Agenda

2023–24 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
S. 923 Bennet (CO)	**Better Mental Health Care for Americans Act:** Would require parity for mental health services in Medicaid, Medicare Advantage (MA) and Medicare Part D. Would also enhance Medicaid and Medicare payments for integrating mental health and substance use disorder services with physical care. Finally, would create a 54-month Medicaid demonstration project to increase state funding for enhanced access to mental health services for children. In addition, would require MA plans to verify and update provider directories at least every 90 days and remove a non-participating provider within two business days of notification. ***Potential CalOptima Health Impact****:* Increased access to behavioral health services for CalOptima Health members; increased funding for contracted providers; increased staff oversight of OneCare provider directory.	**03/22/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
S. 1378 Cortez Masto (NV)	**Connecting Our Medical Providers with Links to Expand Tailored and Effective (COMPLETE) Care Act:** Would improve access to timely, effective mental health care in the primary care setting by increasing Medicare payments to providers for implementing integrated care models. ***Potential CalOptima Health Impact****:* Increased resources and access to behavioral health services for CalOptima Health OneCare members; increased funding for contracted providers.	**04/27/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 326 Eggman	**The Behavioral Health Services Act:** If passed, would place this act on the March 5, 2024, statewide primary election ballot. If approved by voters, would rename the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA), expand services to include substance use disorders, revise the distribution of up to $36 million for behavioral health workforce funding and remove provisions related to innovative programs by, instead, establishing priorities and a program — administered by counties — to provide a housing support service. ***Potential CalOptima Health Impact****:* Increased resources and access to behavioral health services and housing interventions for CalOptima Health members.	**08/22/2023** Passed Assembly Health Committee; referred to Assembly Housing & Community Development Committee **05/24/2023** Passed Senate floor	CalOptima Health: Watch
SB 363 Eggman	**Behavioral Health Facilities Database:** No later than January 1, 2026, would require the California Department of Health Care Services (DHCS) to develop a real-time, internet-based database to display information about beds in certain facilities, including chemical dependency recovery hospitals, acute psychiatric hospitals and mental health rehabilitation centers, to identify the availability of inpatient and residential mental health or substance use disorder treatment. ***Potential CalOptima Health Impact:*** Increased resources and access to behavioral health services for CalOptima Health Medi-Cal members.	**06/13/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/24/2023** Passed Senate floor; referred to Assembly	CalOptima Health: Watch
AB 492 Pellerin	**Reproductive and Behavioral Health Integration Pilot Programs:** Would provide grants, incentive payments or other financial support to Medi-Cal managed care plans (MCPs) to partner with providers for the development and implementation of behavioral health integration pilot programs to improve access to services. Partnering providers must be enrolled in the Family Planning, Access, Care, and Treatment (Family PACT) program and provide reproductive health services. ***Potential CalOptima Health Impact*:** Increased funding and access to reproductive and behavioral health services.	**06/14/2023** Referred to Senate Health Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 512 Waldron	**Behavioral Health Facilities Database:** Would require the California Health and Human Services Agency (CalHHS) to create a committee to study how to develop a real-time, internet-based system, usable by hospitals, clinics, law enforcement, paramedics and emergency medical technicians, and other health care providers to display information about available beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities and residential alcoholism or substance abuse treatment facilities in order to identify available facilities for the temporary treatment of individuals experiencing a mental health or substance use disorder crisis. ***Potential CalOptima Health Impact*:** Increased efficiency and timeliness of facility referrals; decreased visits to the emergency department.	**03/14/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 531 Irwin	**The Behavioral Health Infrastructure Bond Act of 2023:** If passed, would place this bond act on the March 5, 2024, statewide primary election ballot. If approved by voters, would authorize $4.6 million in bonds to fund supportive housing construction and community-based treatment facilities for those experiencing or at risk of homelessness and living with behavioral health challenges. ***Potential CalOptima Health Impact*:** Increased behavioral health services and community supports for some CalOptima Health members.	**07/12/2023** Passed Senate Governance & Finance Committee; referred to Senate Appropriations Committee **05/30/2023** Passed Assembly floor	CalOptima Health: Watch
AB 940 Villapudua	**Eating Disorder Treatment:** Would expand the approved facilities for inpatient treatment of eating disorders to include psychiatric health facilities. ***Potential CalOptima Health Impact*:** Increased access to treatment for eating disorders.	**04/11/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch
AB 1316 Irwin	**Psychiatric Emergency Medical Conditions:** Would require the Medi-Cal program to cover emergency services and care necessary to treat an emergency medical condition, including screening examinations necessary to determine the presence or absence of an emergency medical condition. ***Potential CalOptima Health Impact*:** Increased scope of behavioral health services for CalOptima Health Medi-Cal members.	**04/10/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1470 Quirk-Silva	**Behavioral Health Documentation Standards:** Would require DHCS to standardize data elements relating to documentation requirements, including medically necessary criteria and develop standard forms containing information necessary to properly adjudicate claims. No later than July 1, 2025, regional personnel training on documentation should be completed along with the exclusive use of the standard forms. ***Potential CalOptima Health Impact*:** New data requirements; additional training for CalOptima Health behavioral health staff on new documentation.	**06/28/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/01/2023** Passed Assembly floor	CalOptima Health: Watch
Budget			
SB 101 Skinner **AB 102** Ting	**Budget Act of 2023:** Makes appropriations for the government of the State of California for Fiscal Year (FY) 2023–24. Total spending is $310.8 billion, of which $226 billion is from the General Fund. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed FY 2023–24 Enacted State Budget Analysis.	**7/10/2023** Signed into law	CalOptima Health: Watch
AB 118 Committee on Budget	**Health Trailer Bill:** Consolidates and enacts certain budget trailer bill language containing the policy changes needed to implement health-related expenditures in the FY 2023-24 state budget. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed FY 2023–24 Enacted State Budget Analysis.	**07/10/2023** Signed into law	CalOptima Health: Watch
AB 119 Committee on Budget	**Managed Care Organization (MCO) Provider Tax Trailer Bill:** Renews the MCO provider tax, retroactively effective April 1, 2023, through December 31, 2026, and restructures the tax tiers and amounts. Also creates the Managed Care Enrollment Fund to fund Medi-Cal programs. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed FY 2023–24 Enacted State Budget Analysis.	**06/29/2023** Signed into law	CalOptima Health: Watch
California Advancing and Innovating Medi-Cal (CalAIM)			
AB 586 Calderon	**Community Support: Climate Change or Environmental Remediation Devices:** Would add "climate change remediation" as a Community Support option, defined as the coverage and installation of devices to address health-related complications, barriers or other factors linked to extreme weather or other climate events, including air conditioners, heaters, air filters and generators. ***Potential CalOptima Health Impact:*** New services available for CalOptima Health Medi-Cal members to address social determinants of health (SDOH).	**04/11/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1338 Petrie-Norris	**Community Support: Fitness**: Would add fitness, physical activity, or recreational sports programs, activities, or memberships as a Community Support option. ***Potential CalOptima Health Impact:*** New services available for CalOptima Health Medi-Cal members to address SDOH.	**04/18/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
Covered Benefits			
SB 257 Portantino	**Mammography:** Beginning January 1, 2025, would require health plans to cover, without cost sharing, screening mammography and medically necessary diagnostic breast imaging, including following an abnormal mammography result and for individuals with a risk factor associated with breast cancer. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**06/27/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/26/2023** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose
SB 324 Limón	**Endometriosis:** Would add any clinically indicated treatment for endometriosis as a covered benefit without prior authorization or other utilization review. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**06/27/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/24/2023** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose
SB 339 Wiener	**Human Immunodeficiency Virtus (HIV) Preexposure Prophylaxis (PrEP) and Postexposure Prophylaxis (PEP):** Would require the Medi-Cal program to cover PrEP and PEP furnished by a pharmacist for up to a 90-day course. ***Potential CalOptima Health Impact:*** Expanded Medi-Cal Rx benefit for CalOptima Health Medi-Cal members.	**07/11/2023** Passed Assembly Business and Professions Committee; referred to Assembly Appropriations Committee **05/22/2023** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose Unless Amended
SB 496 Limón	**Biomarker Testing:** No later than July 1, 2024, would add biomarker testing, including whole genome sequencing, as a covered Medi-Cal benefit for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of a disease or condition to guide treatment decisions, if the test is supported by medical and scientific evidence, as prescribed. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**07/11/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/24/2023** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose Unless Amended

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 694 Eggman	**Self-Measured Blood Pressure (SMBP) Devices and Services**: Would add SMBP devices and related services as covered Medi-Cal benefits for the treatment of high blood pressure. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**06/20/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch CalPACE: Support
AB 47 Boerner Horvath	**Pelvic Floor Physical Therapy**: Beginning January 1, 2024, would require health plans to provide coverage for pelvic floor physical therapy after pregnancy. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health Medi-Cal members.	**04/20/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch CAHP: Oppose
AB 365 Aguiar-Curry	**Continuous Glucose Monitors (CGMs):** Would add CGMs and related supplies as a covered Medi-Cal benefit, subject to utilization controls based on clinical practice guidelines. Would also authorize DHCS to require a manufacturer of CGMs to enter into a rebate agreement with DHCS. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**06/28/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch CalPACE: Support
AB 425 Alvarez	**Pharmacogenomics Advancing Total Health for All Act:** Would add pharmacogenomic testing as a covered Medi-Cal benefit, defined as laboratory genetic testing to identify how an individual's genetics may impact the efficacy, toxicity and safety of medications. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health Medi-Cal members.	**06/29/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch
AB 608 Schiavo	**Perinatal Services**: Would require DHCS to cover additional perinatal assessments, individualized care plans and other services during the one-year postpartum Medi-Cal eligibility period at least proportional to those available during pregnancy and the initial 60-day postpartum period. DHCS would be required to collaborate with the California Department of Public Health (CDPH) and stakeholders to determine the specific levels of additional coverage. Would also allow perinatal services to be rendered by a nonlicensed perinatal health worker in a beneficiary's home or other community setting away from a medical site. Lastly, would allow such workers to be supervised by a community-based organization or local health jurisdiction. ***Potential CalOptima Health Impact:*** Expanded covered benefit and associated provider network for CalOptima Health Medi-Cal members.	**07/11/2023** Passed Senate Governmental Organizational Committee; referred to Senate Appropriations Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 620 Connolly	**Digestive and Metabolic Disorders:** Beginning January 1, 2024, would require health plans to expand coverage for the testing and treatment of phenylketonuria (PKU) to include other digestive and inherited metabolic disorders. Coverage would include the formulas and special food products that are part of a prescribed diet. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**06/29/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 847 Rivas, L.	**Pediatric Palliative Care Services**: Would extend Medi-Cal coverage for palliative care and hospice services after 21 years of age until 26 years of age for individuals who were previously determined eligible prior to 21 years of age. Would require Medi-Cal MCPs to be liable for payment of out-of-county services if unavailable in county of residence. ***Potential CalOptima Health Impact:*** Expanded covered benefit for certain CalOptima Health Medi-Cal members; increased costs for out-of-county services.	**07/06/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/30/2023** Passed Assembly floor	CalOptima Health: Watch
AB 907 Lowenthal	**PANDAS and PANS**: Beginning January 1, 2024, would require a health plan to provide coverage for prophylaxis, diagnosis and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) prescribed or ordered by a provider. ***Potential CalOptima Health Impact:*** New covered benefit for pediatric CalOptima Health Medi-Cal members.	**06/28/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 1036 Bryan	**Emergency Medical Transportation:** Would require a physician to certify upon patient arrival at an emergency room via emergency medical transportation whether an emergency medical condition existed and required emergency medical transportation. If certified, would require a health plan to provide coverage for emergency medical transportation. ***Potential CalOptima Health Impact:*** Increased CalOptima Health costs for reimbursement of emergency transportation services.	**04/18/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch
AB 1060 Ortega	**Naloxone Hydrochloride:** Would add prescription and non-prescription naloxone hydrochloride or another drug approved by the U.S. Food and Drug Administration as a covered benefit under the Medi-Cal program for the complete or partial reversal of an opioid overdose. ***Potential CalOptima Health Impact:*** New Medi-Cal Rx benefit for CalOptima Health Medi-Cal members.	**06/28/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/25/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose Unless Amended

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1085 Maienschein	**Housing Support Services**: Would require DHCS, if the state has sufficient network capacity, to add housing support services as a covered Medi-Cal benefit for individuals experiencing or at risk of homelessness, consistent with the following Community Supports offered through CalAIM: • Housing Transition Navigation Services • Housing Deposits • Housing Tenancy and Sustaining Services ***Potential CalOptima Health Impact:*** Formalization of certain Community Support services as covered benefits for eligible CalOptima Health Medi-Cal members.	**06/14/2023** Passed Sente Health Committee; referred to Senate Appropriations Committee **05/30/2023** Passed Assembly floor	CalOptima Health: Watch CalPACE: Support
AB 1644 Bonta	**Medically Supportive Food**: Would add medically supportive food and nutrition intervention plans as covered Medi-Cal benefits, when determined to be medically necessary to a patient's medical condition by a provider or plan. The benefit would be based in part on the following Community Support offered through CalAIM: Medically Tailored Meals. ***Potential CalOptima Health Impact:*** Formalization and expansion of certain Community Support services as covered benefits for eligible CalOptima Health Medi-Cal members.	**04/25/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
Medi-Cal Eligibility and Enrollment			
S. 423 Van Hollen (MD) **H.R. 1113** Bera (CA)	**Easy Enrollment in Health Care Act:** To streamline and increase enrollment into public health insurance programs, would allow taxpayers to request their federal income tax returns include a determination of eligibility for Medicaid, the Children's Health Insurance Program (CHIP) or advance premium tax credits to purchase insurance through a health plan exchange. Taxpayers could also consent to be automatically enrolled into any such program or plan if they were subject to a zero net premium. Would also make individuals eligible for Medicaid or CHIP based on a prior finding of eligibility for the Temporary Assistance for Needy Families program or the Supplemental Nutrition Assistance Program. ***Potential CalOptima Health Impact*:** Expanded eligibility standards and procedures for enrollment of CalOptima Health members.	**02/14/2023** Introduced; referred to committees	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1481 Boerner Horvath	**Medi-Cal Presumptive Eligibility for Pregnancy**: Would expand presumptive eligibility for pregnant women to all pregnant people, renaming the program "Presumptive Eligibility for Pregnant People" (PE4PP). Would make a presumptively eligible pregnant person eligible for all covered Medi-Cal benefits, except for inpatient services and institutional long-term care. If an application for full-scope Medi-Cal benefits is submitted within 60 days of a PE4PP determination, PE4PP coverage would be effective until the Medi-Cal application is approved or denied. ***Potential CalOptima Health Impact:*** Improved Medi-Cal enrollment process and timelier access to covered benefits for eligible pregnant individuals.	**07/13/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/25/2023** Passed Assembly floor	CalOptima Health: Watch
AB 1608 Patterson	**Regional Center Clients:** Would exempt from mandatory Medi-Cal MCP enrollment any dual-eligible and non-dual-eligible Medi-Cal beneficiaries who receive services from a regional center and use the Medi-Cal fee-for-service (FFS) delivery system as secondary form of health coverage. ***Potential CalOptima Health Impact:*** Decreased number of CalOptima Health members.	**03/27/2023** Amended and re-referred to Assembly Health Committee	CalOptima Health: Watch
Medi-Cal Operations and Administration			
H.R. 2811 Arrington (TX)	**Limit, Save, Grow Act of 2023:** Would require Medicaid beneficiaries ages 19–55 without dependents to work, complete community service and/or participate in a work training program for at least 80 hours per month for at least three months per year. Exemptions would be provided for those who are pregnant, physically or mentally unfit for employment, complying with work requirements under a different federal program, participating in a drug or alcohol treatment program, or enrolled in school at least half-time. The U.S. Department of Health and Human Services estimates that 294,981 Medi-Cal beneficiaries in Orange County would be subject to the proposed work requirements without an exemption. ***Potential CalOptima Health Impact:*** Disenrollment of certain CalOptima Health Medi-Cal members, especially those who experience homelessness, who are not exempted from work requirements.	**04/26/2023** Passed House floor; referred to Senate Budget Committee	CalOptima Health: Concerns ACAP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 557 Hart	**Brown Act Flexibilities:** Would permanently extend current Brown Act teleconferencing flexibilities — when a declared state of emergency is in effect — beyond January 1, 2024. Would also extend the period for a legislative body to make findings related to a continuing state of emergency from every 30 days to every 45 days. ***Potential CalOptima Health Impact:*** Extended teleconferencing flexibilities for Board and advisory committee meetings.	**06/27/2023** Passed Senate Judiciary Committee; referred to Senate floor **05/15/2023** Passed Assembly floor	CalOptima Health: Watch
AB 719 Boerner Horvath	**Public Transit Contracts**: Would require Medi-Cal managed care plans to contract with public paratransit operators for nonmedical transportation (NMT) and nonemergency medical transportation (NEMT) services. Would require reimbursement to be based on the Medi-Cal FFS rates for those services. ***Potential CalOptima Health Impact:*** Execution of additional NMT and NEMT contracts; increased transportation options for CalOptima Health Medi-Cal members.	**07/05/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/30/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose
AB 1202 Lackey	**Pediatric Time and Distance Standards:** Would require DHCS to report to the Legislature the results of an analysis to identify the number and geographic distribution of Medi-Cal providers needed to ensure compliance with time and distances standards for pediatric primary care. ***Potential CalOptima Health Impact:*** Increased network analysis and reporting to DHCS.	**07/12/2023** Passed Senate Health Committee; refereed to Senate Appropriations Committee **05/31/2023** Passed Assembly	CalOptima Health: Watch
AB 1690 Kalra	**Universal Health Care Coverage**: States the intent of the Legislature to guarantee accessible, affordable, equitable and high-quality health care for all Californians through a comprehensive universal single-payer health care program. ***Potential CalOptima Health Impact:*** Unknown but potentially significant impacts to the Medi-Cal program and CalOptima Health care delivery, financing and administration.	**02/17/2023** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Older Adult Services			
S. 1002 Cassidy (LA)	**No Unreasonable Payments, Coding, or Diagnoses for the Elderly (No UPCODE) Act:** Would modify the MA risk adjustment model to prevent overpayment to MA plans, as follows: • Utilization of two years instead of one of diagnostic data • Exclusion of outdated diagnoses solely included on health risk assessments • Coding adjustment to account for other payment differences between MA and Medicare FFS ***Potential CalOptima Health Impact:*** Decreased reimbursement rates from the Centers for Medicare and Medicaid Services (CMS) for CalOptima Health OneCare members.	**03/28/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
S. 1703 Carper (DE) **H.R. 3549** Wenstrup (OH)	**Program of All-Inclusive Care for the Elderly (PACE) Part D Choice Act of 2023:** Would allow a Medicare-only PACE participant to opt out of drug coverage provided by the PACE program and instead enroll in a standalone Medicare Part D prescription drug plan that results in equal or lesser out-of-pocket costs. PACE programs would be required to educate their participants about this option. ***Potential CalOptima Health Impact:*** Increased enrollment into CalOptima Health PACE by Medicare-only beneficiaries due to decreased out-of-pocket costs.	**05/18/2023** Introduced; referred to committees	**08/30/2023** CalOptima Health: SUPPORT NPA: Support
SB 311 Eggman	**Medicare Part A Buy-In:** No later than January 1, 2024, would require DHCS to submit a Medicaid state plan amendment to enter into a Medicare Part A buy-in agreement with CMS. This would allow DHCS to automatically enroll individuals with a Part A premium into Part A on their behalf. ***Potential CalOptima Health Impact:*** Simplified Medicare enrollment and increased financial stability for dual-eligible CalOptima Health members with Part A premium requirements.	**06/13/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch LHPC: Support CalPACE: Support
AB 1022 Mathis	**PACE Rates and Assessments**: Would require PACE capitation rates to also reflect the frailty level and risk associated with participants. In addition, would expand a PACE organization's authority to use video telehealth to conduct all assessments. ***Potential CalOptima Health Impact:*** Increased capitation rates for CalOptima Health PACE participants; expanded use of video telehealth assessments.	**03/02/2023** Referred to Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1223 Hoover	**PACE Audits:** Would require DHCS to perform program audits of PACE organizations and to develop and maintain standards, rules and auditing protocols, including related to data collection, technical assistance, formal decisions and enforcement of non-compliance. ***Potential CalOptima Health Impact:*** Modified audit protocols for CalOptima Health PACE.	**03/13/2023** Amended and re-referred to Assembly Health Committee	CalOptima Health: Watch
AB 1230 Valencia	**Special Needs Plans (SNPs)**: No later than January 1, 2025, would require DHCS to offer contracts to health plans for Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) to provide care to dual eligible beneficiaries. ***Potential CalOptima Health Impact:*** Increased number of SNPs in Orange County; decreased number of CalOptima Health OneCare members.	**04/20/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch LHPC: Oppose
Providers			
H.R. 497 Duncan (SC)	**Freedom for Health Care Workers Act:** would repeal the rule issued by CMS on November 5, 2021, that requires health care providers participating in the Medicare and Medicaid programs to ensure staff are fully vaccinated against COVID-19**.** ***Potential CalOptima Health Impact:*** Elimination of COVID-19 vaccination mandate for CalOptima Health PACE staff and contracted providers.	**01/31/2023** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch
SB 598 Skinner	**Prior Authorization "Gold Carding"**: Beginning January 1, 2026, would prohibit a health plan from requiring a contracted provider to obtain a prior authorization for any services if the plan approved or would have approved no less than 90% of the prior authorization requests submitted by the provider in the most recent one-year contracted period. Would also broadly prohibit prior authorization requirements for any services approved by a health plan at least 95% of the time. ***Potential CalOptima Health Impact:*** Implementation of new utilization management (UM) procedures to assess provider approval rates; decreased number of prior authorizations.	**07/11/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/25/2023** Passed Senate floor	**08/30/2023** CalOptima Health: OPPOSE CAHP: Oppose LHPC: Oppose
SB 819 Eggman	**Medi-Cal Mobile Health Care Site Enrollment:** Would exempt intermittent or mobile health care sites from enrolling in Medi-Cal as a separate provider if operated by a government-operated primary care clinic that is exempt from licensure by CDPH. ***Potential CalOptima Health Impact:*** Expansion of intermittent and mobile health care sites; increased access to care for CalOptima Health members.	**08/16/2023** Passed Assembly Appropriations Committee; referred to Assembly floor **05/04/2023** Passed Senate floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 236 Holden	**Provider Directory Audits:** Would require health plans to annually audit and delete inaccurate listings from its provider directories. Would also require a provider directory to be 60% accurate by January 1, 2024, with increasing percentage accuracy each year until the directories are 95% accurate by January 1, 2027. In addition, plans would be subject to penalties for failure to meet the prescribed benchmarks and for each inaccurate listing in its directories. Finally, beginning July 1, 2024, would require plans to delete a provider from its directory if a plan has not reimbursed the provider in the prior year. ***Potential CalOptima Health Impact:*** Increased oversight of CalOptima Health provider directory; increased coordination with contracted providers; increased penalty payments to DHCS.	**03/14/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
AB 564 Villapudua	**Medi-Cal Claim Signatures**: Would allow Medi-Cal providers to submit electronic signatures for claims and remittance forms. ***Potential CalOptima Health Impact:*** Reduced administrative burden for CalOptima Health contracted providers.	**06/14/2023** Referred to Senate Health Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch
AB 815 Wood	**Provider Credentialing**: Would require CalHHS to create a provider credentialing board that certifies entities to credential providers in lieu of a health plan's credentialing process, effective July 1, 2025. Would require a health plan to accept a credential from such entities without imposing additional criteria and to pay a fee to such entities based on the number of contracted providers credentialed. Health plans could use their own credentialing processes for any providers who are not credentialed by certified entities. ***Potential CalOptima Health Impact***: Reduced credentialing application workload for CalOptima Health staff; reduced quality oversight of contracted providers.	**06/07/2023** Referred to Senate Health Committee **05/30/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Concerns LHPC: Oppose Unless Amended
AB 904 Calderon	**Doula Access**: Beginning January 1, 2025, would require a health plan to develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas. ***Potential CalOptima Health Impact:*** Increased access to prenatal care for eligible CalOptima Health Medi-Cal members; additional provider contracting and credentialing, additional staff time for program management.	**06/21/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/30/2023** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 931 Irwin	**Physical Therapy Prior Authorization**: Beginning January 1, 2025, would prohibit health plans from requiring prior authorization for the initial 12 treatment visits for a new episode of care for physical therapy. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**06/14/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/01/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 1122 Bains	**Medi-Cal Provider Applications:** Would allow providers to submit an alternative type of primary, authoritative source documentation as proof of information required on a Medi-Cal enrollment application. Would also authorize providers to submit applications up to 30 days before having an established place of business. ***Potential CalOptima Health Impact:*** Streamlined Medi-Cal provider enrollment process; increased number of CalOptima Health contracted providers.	**07/05/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/25/2023** Passed Assembly floor	CalOptima Health: Watch
AB 1241 Weber	**Medi-Cal Telehealth Access:** Would require Medi-Cal telehealth providers to maintain and follow protocols to either offer in-person services or arrange a referral to in-person services. However, this would not require a provider to schedule an appointment with a different provider on behalf of a patient. ***Potential CalOptima Health Impact:*** Continued flexibility to access in-person, video and audio-only health care services for CalOptima Health Medi-Cal members.	**06/07/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **04/27/2023** Passed Assembly floor	CalOptima Health: Watch
AB 1288 Reyes	**Medication-Assisted Treatment Prior Authorization**: Would prohibit health plans from requiring prior authorization for a naloxone product, buprenorphine product, methadone or long-acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder, when prescribed according to generally accepted national professional guidelines. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**08/14/2023** Passed Senate Appropriations Committee; referred to Senate floor **05/18/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
Rates & Financing			
S. 570 Cardin (MD) **H.R. 1342** Barragan (CA)	**Medicaid Dental Benefit Act of 2023:** Would require state Medicaid programs to cover dental and oral health services for adults. Would also increase the Federal Medical Assistance Percentage (FMAP) (i.e., federal matching rate) for such services. CMS would be required to develop oral health quality and equity measures and conduct outreach relating to dental and oral health coverage. ***Potential CalOptima Health Impact:*** Increased payments to CalOptima Health and contracted providers; additional quality metrics.	**02/28/2023** Introduced; referred to committees	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
S. 1038 Welch (VT) **H.R. 1613** Carter (GA)	**Drug Price Transparency in Medicaid Act of 2023:** Would prohibit "spread pricing" for payment arrangements with pharmacy benefit managers (PBMs) under Medicaid. Would also require a pass-through pricing model that focuses on cost-based pharmacy reimbursement and dispensing fees. ***Potential CalOptima Health Impact*:** Lower costs and increased transparency in drug prices under the Medi-Cal Rx program,	**03/29/2023** Introduced; referred to Committees	CalOptima Health: Watch
H.R. 485 McMorris (WA)	**Protecting Health Care for All Patients Act of 2023:** Would prohibit all federally funded health care programs from using quality-adjusted life years (i.e., measures that discount the value of a life based on disability) to determine coverage and payment determinations for treatments and prescription drugs. ***Potential CalOptima Health Impact:*** Modified authorization limits for certain CalOptima Health members.	**03/24/2023** Passed by House Energy and Commerce Committee; referred to House floor	CalOptima Health: Watch
SB 282 Eggman	**Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Same-Day Visits**: Would authorize reimbursement for a maximum of two separate visits that take place on the same day at a single FQHC or RHC site, whether through a face-to-face or telehealth-based encounter (e.g., a medical visit and dental visit on the same day). In addition, would add a licensed acupuncturist within those health care professionals covered under the definition of a "visit." ***Potential CalOptima Health Impact:*** Timelier access to services at CalOptima Health's contracted FQHCs.	**07/12/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch LHPC: Support
SB 340 Eggman	**Eyeglasses Reimbursement**: Would authorize a provider to purchase eyeglasses from a private entity instead of from the Prison Industry Authority for the purpose of Medi-Cal reimbursement for covered optometric services. ***Potential CalOptima Health Impact:*** Timelier access to prescription eyeglasses for CalOptima Health Medi-Cal members.	**06/15/2023** Referred to Assembly Health Committee and Assembly Public Safety Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch
SB 870 Caballero	**MCO Tax:** Would renew the MCO tax on health plans, which expired on January 1, 2023, to an unspecified future date. Would also modify the tax rates to unspecified percentages that are based on the Medi-Cal membership of the health plan. ***Potential CalOptima Health Impact:*** Increased tax liability on CalOptima Health.	**04/26/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 55 Rodriguez	**Ground Ambulance Transportation**: Effective January 1, 2024, would require Medi-Cal MCPs to implement a value-based purchasing model that increases reimbursement to ground ambulance transportation providers who meet certain workforce standards. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health's contracted transportation providers; increased costs for CalOptima Health.	**04/25/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 488 Nguyen, S.	**Vision Loss:** Would modify the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program measures and milestones to include program access, staff training and capital improvement measures aimed at addressing the needs of SNF residents with vision loss. ***Potential CalOptima Health Impact:*** Modified payments to CalOptima Health contracted SNFs; increased data collection, tracking and reporting requirements; improved quality of life for certain members with vision loss.	**03/27/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch
AB 576 Weber	**Abortion Reimbursement**: Would require DHCS to fully reimburse Medi-Cal providers for providing medication to terminate a pregnancy that aligns with clinical guidelines, evidence-based research and provider discretion. ***Potential CalOptima Health Impact:*** Increased financial stability for eligible CalOptima Health contracted providers.	**06/28/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch
AB 1549 Carrillo	**FQHC and RHC Rates:** Would require that DHCS's per-visit rates to FQHCs and RHCs account for costs that are reasonable and related to the provision of covered services, the intensity of activities taking place in an average visit, the length or duration of a visit and the number of activities provided during a visit. ***Potential CalOptima Health Impact:*** Increased financial stability of CalOptima Health's contracted FQHCs.	**04/25/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 1698 Wood	**Medi-Cal Funding**: States the intent of the Legislature to enact future legislation to increase overall funding and reimbursement for the Medi-Cal program. ***Potential CalOptima Health Impact***: Increased financial stability for CalOptima Health and its contracted providers.	**02/17/2023** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Social Determinants of Health			
H.R. 1066 Blunt Rochester (DE)	**Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants Act of 2023:** Would require CMS to update guidance at least once every three years to help states address SDOH under Medicaid and CHIP. ***Potential CalOptima Health Impact:*** Increased opportunities for CalOptima Health to address SDOH.	**02/17/2023** Introduced; referred to House Energy and Commerce Committee	CalOptima Health: Watch
H.R. 3746 McHenry	**Fiscal Responsibility Act (FRA) of 2023:** Suspends the $31 trillion debt limit until January 1, 2025, and includes additional policies to cap discretionary spending limits and modify work reporting requirements for certain safety net programs. Most notably, modifies work requirements for the Supplemental Nutrition Assistance Program (SNAP). Specifically, through October 1, 2030, raises the age of SNAP recipients subject to work requirements from 18–49 to 18–55 years old but also creates new exemptions that waive SNAP work requirements for veterans, individuals experiencing homelessness and young adults ages 18–24 years old who are aging out of the foster care system. ***Potential CalOptima Health Impact:*** Increased number of CalOptima Health members eligible for CalFresh.	**06/03/2023** Signed into law	CalOptima Health: Watch
AB 85 Weber	**SDOH Screenings:** Would add SDOH screenings as a covered Medi-Cal benefit. Would also require health plans to provide primary care providers with adequate access to community health workers, social workers and peer support specialists. Would also FQHCs and RHCs to be reimbursed for these services at the Med-Cal FFS rate. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**06/28/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/25/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 257 Hoover	**Encampment Restrictions:** Would prohibit a person from sitting, lying, sleeping or placing personal property in any street, sidewalk or other public property within 500 feet of a school, daycare center, park or library. ***Potential CalOptima Health Impact:*** Increased outreach and support services for unsheltered CalOptima Health Medi-Cal members.	**03/07/2023** Failed passage in Assembly Public Safety Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 271 Quirk-Silva	**Homeless Death Review Committee:** Would authorize counties to establish a homeless death review committee for the purpose of gathering information to identify the root causes of the deaths of homeless individuals and to determine strategies to improve coordination of services for the homeless population. ***Potential CalOptima Health Impact:*** Increased coordination and data review between the County of Orange and CalOptima Health.	**08/14/2023** Assembly concurred in amendments; referred to Governor **07/13/2023** Passed Senate floor **03/06/2023** Passed Assembly floor	**03/02/2023** CalOptima Health: SUPPORT

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

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

Last Updated: August 23, 2023

2023 Federal Legislative Dates

January 3	118th Congress, 1st Session convenes
July 31–September 4	Summer recess for Senate
July 31–September 11	Summer recess for House
December 15	1st Session adjourns

Source: Floor Calendars, United States Congress: https://www.congress.gov/calendars-and-schedules

2023 State Legislative Dates

January 4	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
February 17	Last day for legislation to be introduced
March 30–April 10	Spring recess
April 28	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house
May 5	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house
May 19	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house
May 30–June 2	Floor session only
June 2	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 14	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 14–August 14	Summer recess
September 1	Last day for fiscal committees to report bills in their second house to the Floor
September 5–14	Floor session only
September 8	Last day to amend bills on the Floor
September 14	Last day for each house to pass bills; final recess begins upon adjournment
October 14	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2023 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima Health

CalOptima Health is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to serve member health with excellence and dignity, respecting the value and needs of each person. We provide coverage through three major programs: Medi-Cal, OneCare (HMO D-SNP) and the Program of All-Inclusive Care for the Elderly (PACE).

FY 2023–24 Enacted State Budget Analysis

Table of Contents

Background

On January 10, 2023, Gov. Gavin Newsom released the Fiscal Year (FY) 2023–24 Proposed State Budget, effective July 1, 2023. The proposed budget's total spending of $297 billion ($223.6 billion General Fund [GF]) reflected an estimated $22.5 billion deficit and a 9.8% decrease in overall spending compared to the FY 2022–23 Enacted Budget.

On May 12, Gov. Newsom released the FY 2023–24 Revised Budget Proposal, also known as the May Revise, with total funding at $306 billion, including $224 billion GF. As tax revenues continued to decline, the projected budget deficit increased by $9.3 billion compared to January Proposed Budget — totaling a $31.5 billion deficit. Nevertheless, the governor continued to present a balanced budget — largely without program cuts — through spending delays, shifts to funding sources, pullbacks of unused expenditures, new revenue sources, borrowing and limited reserve withdrawal.

To meet the constitutionally obligated deadline to pass a balanced budget, on June 15, the State Senate and State Assembly both passed Senate Bill (SB) 101, a placeholder budget representing the Legislature's joint counterproposal to the May Revise. Once a final budget agreement deal was reached between the governor and legislative leaders, the governor signed into law the placeholder state budget (SB 101) on June 27 and the final, agreed-upon budget revisions (Assembly Bill [AB] 102) on July 10. In addition to the budget, the governor also signed the Managed Care Organization (MCO) Tax Trailer Bill (AB 119) on June 29 and the consolidated Health Trailer Bill (AB 118) on July 10, which contain the policy changes needed to implement health-related budget expenditures. Together, these bills represent the FY 2023–24 Enacted Budget.

Overview

As the second largest budget in California history, the FY 2023–24 Enacted Budget sits at $310.8 billion, including nearly $226 billion GF spending, which attempts to close the gap on a $32 billion deficit while safeguarding $37.8 billion in reserve funds. This represents a 4.4% decrease in GF spending compared to the FY 2022–23 Enacted Budget ($234.4 billion GF). To achieve a balanced budget this FY, certain commitments will be delayed or added to the FY 2024–25 budget as a future investment.

The enacted budget estimates Medi-Cal spending of $151.2 billion ($37.6 billion GF), an 11.7% total increase (21.7% GF increase) from FY 2022–23, despite the fact that average Medi-Cal caseload in FY 2023–24 is expected to decrease by 7.2% to 14.2 million beneficiaries

as redeterminations resume following the end of the COVID-19 public health emergency (PHE). Total COVID-19-specific impacts on the Medi-Cal budget impacts are projected to decline overall, but GF costs are predicted to increase due to the phase-out of federal relief funding related to the PHE.

Managed Care Organization (MCO) Provider Tax

With renewed commitments to Medi-Cal spending, the enacted budget retroactively implements a new MCO Provider Tax, effective April 1, 2023, through December 31, 2026. Over the period of the tax, a total of $19.4 billion in net benefits will be generated — with $8.3 billion allocated for GF offsets to support a balanced budget and the remaining $11.1 billion for historic new investments in the Medi-Cal program, including targeted increases to Medi-Cal rates, access and provider participation.

In facilitating the $11.1 billion allocation, the new Medi-Cal Provider Payment Reserve Fund will support investments in Medi-Cal that maintain and expand programs by increasing quality of health care delivery and reducing barriers to care. These funds will preserve eligibility and benefit expansions in the Medi-Cal program, strengthen the program's participation, especially in underserved areas and in primary and preventive care, and maximize opportunities to draw additional federal matching funds to the Medi-Cal program. While a detailed plan for most investments will be submitted as part of the FY 2024–25 budget next year, specific limited investments beginning in FY 2023–24 can be found below:

Rate Increases in the Medi-Cal Program: No sooner than January 1, 2024, reimbursement rates for primary care services (including nurse practitioners and physician assistants), maternity care (including obstetric and doula services), and certain outpatient non-specialty mental health services will increase to at least 87.5% of Medicare rates. This is an adjustment to base rates that takes into account current Proposition 56 supplemental payments and the elimination of AB 97 rate reductions for these services. Estimated costs to increase provider rates are $237.4 million ($98.2 million Medi-Cal Provider Payment Reserve Fund) in FY 2023–24 and $580.5 million ($240.1 million Medi-Cal Provider Payment Reserve Fund) annually thereafter.

Distressed Hospital Loan Program: $300 million is allocated to support not-for-profit and public hospitals facing closure or facilitating the reopening of a hospital. The Department of Health Care Access and Information (HCAI) and California Health Facilities Financing Authority will provide one-time interest-free cashflow loans of up to $150 million from the Medi-Cal Provider Payment Reserve Fund in FY 2023–24 and up to $150 million from the GF in the previous FY 2022–23 to distressed hospitals in need.

Small and Rural Hospital Relief Program: $52.2 million will support rural hospitals to meet compliance standards with the State's seismic mandate with $50 million one-time from the Medi-Cal Provider Payment Reserve and $2.2 million from the Small and Rural Hospital Relief Fund for assessment and construction.

Graduate Medical Education Program: In an effort to increase the number of primary and specialty care physicians in the state — based on demonstrated workforce needs and priorities — $75 million will be expended for the University of California to expand graduate medical education programs and annually thereafter.

Behavioral Health

The state budget continues to address gaps through renewed commitments to modernize current programs in the mental health continuum. The enacted budget includes $40 million ($20 million Mental Health Services Fund; $20 million federal funds) to continue reforming the behavioral health system. As part of the final budget agreement, DHCS will work to implement the governor's proposal to modernize the Mental Health Services Act as well as authorize a general obligation bond to fund the following:

- Unlocked community behavioral health residential settings
- Permanent supportive housing for people experiencing or at risk of homelessness who have behavioral health conditions
- Housing for veterans experiencing or at risk of homelessness who have behavioral health conditions

988 Suicide and Crisis Program: $13.2 million in special funds and federal funds will support a five-year implementation plan for a comprehensive 988 system. Under the health trailer bill language, prior authorization will no longer be required for behavioral health crisis stabilization services and care but authorizes prior authorization for medically necessary mental health or substance use disorder services following stabilization from a behavioral health crisis provided through the 988 system. Additionally, a plan that provides behavioral health crisis services and is contacted by a 988 center or mobile crisis team must authorize post-stabilization care or arrange for prompt transfer of care to another provider within 30 minutes

of initial contact.

Children and Youth Behavioral Health Initiative (CYBHI) Fee Schedule Third Party Administrator (TPA): As part of the CYBHI mandate, an established statewide all-payer fee schedule will reimburse school-linked behavioral health providers who deliver services to students at or near a school-site. $10 million from the Mental Health Services Fund will be expended in support of the statewide infrastructure that will consolidate provider management operations to include credentialing, quality assurance, billing and claims.

CalHOPE: The CalHOPE program is a vital element of the statewide crisis support system. $69.5 million total funding will assist in continuing operations, including media messaging to destigmatize stress and anxiety as well as CalHOPE web services, warm line and partnership opportunities with up to 30 community-based organizations and over 400 peer crisis counselors.

CalFresh

CalFresh — California's implementation of the federal Supplemental Nutrition Assistance Program (SNAP) — sees $35 million in funding for the California Nutrition Incentive Program, which helps members purchase healthy food from farmers' markets. The Legislature also included a line item for $16.8 million in one-time funding to extend the sunset dates for a CalFresh fruit and vegetable pilot EBT program Market Match. For every benefit dollar spent, participants receive an additional dollar to spend on fruits and vegetables at a market within set parameters. The deal also includes $915,000 to trial monthly minimum CalFresh benefit increase from $23 to $50.

California Advancing and Innovating Medi-Cal (CalAIM)

Transitional Rent: DHCS successfully sought an amendment to the CalAIM Transitional Rent Waiver with a commitment of $17.9 million ($6.3 million GF) for an additional community support that may be offered by Medi-Cal MCPs. Under the DHCS budget, the new "Transitional Rent" community support would allow the provision of up to six months of rent or temporary housing to eligible individuals experiencing homelessness or at risk of homelessness and transitioning out of institutional levels of care, a correctional facility, or the foster care system.

Relatedly, the budget also includes an additional $40 million GF for the Provider Access and Transforming Health (PATH) initiative to assist providers with implementing community supports and enhanced care management (ECM) through CalAIM in clinics.

Justice Involved: CalAIM receives a commitment of $9.9 million total funding ($3.8 million GF) in FY 2023–24 for pre-release services, with an additional $225 million estimated subsidy through the PATH program to support correctional agencies in collaborating with county social services department planning and implementation of pre-release Medi-Cal enrollment services.

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT): Formerly referred to as the California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration, BH-CONNECT receives $6.1 billion total ($306.2 million GF; $87.5 million Mental Health Services Fund; $2.1 billion Medi-Cal County Behavioral Health Fund; $3.6 billion federal funds) over a span of five years for DHCS and the California Department of Social Services (DSS) to implement this CalAIM program as soon as January 1, 2024. BH-CONNECT includes statewide and county opt-in components, including rent and temporary housing for up to six months for certain high-needs beneficiaries as well a behavioral health workforce initiative to expand provider capacity and services. DHCS will also seek federal approval of a Medicaid Section 1115 demonstration waiver to expand behavioral health services for Medi-Cal members living with serious mental illness and serious emotional disturbance.

As part of CalAIM Behavioral Health Payment Reform, the budget also provides $250 million GF one-time to support the non-federal share of behavioral health-related services. These funds will help mitigate a significant cash flow concern for counties as they transition from cost-based reimbursement to a fee schedule.

Community Assistance, Recovery and Empowerment (CARE) Act

With a renewed pledge to serve California's most severely impaired population who often struggle with homelessness or incarceration without treatment, the CARE Act receives funding of $52.3 million GF in FY 2023–24, $121 million GF in FY 2024-25 and $151.5 million GF in FY 2025–26 to support ongoing county behavioral health department costs. The CARE Act facilitates delivery of mental health and substance use disorder services to individuals with schizophrenia spectrum or other psychotic disorders who lack medical decision-making competences. The program would connect a person in crisis with a court-ordered

care plan for up to 24 months as a diversion from homelessness, incarcerations, or conservatorship.

Medi-Cal Eligibility

Enrollment Navigators: In addition to the $60 million appropriated in FY 2022–23, $10 million from the GF will be invested into the Health Enrollment Navigators Project (AB 74) over four years. The project aims to promote outreach, enrollment and retention activities in vulnerable populations through partnerships with counties and community-based organizations. Target populations of priority include but are not limited to persons with mental health disorder needs, persons with disabilities, older adults, unhoused individuals, young people of color, immigrants and families of mixed immigration status.

Medi-Cal Expansion to Undocumented Individual: The enacted budget maintains $1.4 billion ($1.2 billion GF) in FY 2023–24 and $3.4 billion ($3.1 billion GF) at full operation, inclusive of In-Home Supportive Services (IHSS) costs, to expand full-scope Medi-Cal eligibility to all income-eligible adults ages 26–49, regardless of immigration status, on January 1, 2024.

Newborn Hospital Gateway: The Newborn Hospital Gateway system provides presumptive eligibility determinations through an electronic process for families to enroll a deemed eligible newborn into the Medi-Cal program from hospitals that elected to participate in the program. Effective July 1, 2024, all qualified Medi-Cal providers participating in presumptive eligibility programs must utilize the Newborn Hospital Gateway system via the Children's Presumptive Eligibility Program portal to report a Medi-Cal-eligible newborn born in their facilities within 72 hours after birth or one business day after discharge.

Whole Child Model (WCM): As part of the budget, WCM will be extended to 15 additional counties no sooner than January 1, 2025. Currently implemented in 21 counties, WCM integrates children's specialty care services provided in the California Children's Services (CCS) program into Medi-Cal managed care plans (MCPs). WCM is already implemented in Orange County. The budget also requires a Medi-Cal MCP participating in WCM to ensure that a CCS-eligible child has a primary point of contact that will be responsible for the child's care coordination and support the referral pathways in non-WCM counties.

Miscellaneous

The enacted budget includes several other adjustments and provisions that potentially impact CalOptima Health:

- **COVID-19 Response:** a one-time funding of $126.6 million will continue ongoing efforts to protect the state's public health against COVID-19 – including maintenance of reporting systems, lab management and CalCONNECT — for oversight case and outbreak investigation.
- **Hepatitis C Virus Equity:** $10 million one-time GF spending, spanning over five years, to expand Hepatitis C Virus services — including outreach, linkage and testing — among high priority populations including young people who use drugs, indigenous communities and those experiencing homelessness.
- **Medi-Cal Rx Naloxone Access Initiative:** a one-time $30 million Opioid Settlements Fund expenditure to support the creation or procurement of a lower cost generic version of naloxone nasal product.
- **Medi-Cal Rx Reproductive Health Costs:** a one-time $2 million GF reappropriation and permissive use of funds for reproductive health care – including statutory changes to provide flexibility for the Medi-Cal Rx program to acquire various pharmaceutical drugs — Mifepristone or Misoprostol — to address urgent and emerging reproductive health needs.
- **Public Health Workforce:** upholds $97.5 million GF over four years for various public health workforce training and development programs.
- **Reproductive Waiver:** $200 million total funds to implement the Reproductive Health Services 1115 demonstration waiver that will support access to family planning and related services for Medi-Cal members as well as support sustainability and system transformation for California's reproductive health safety net.

Next Steps

State agencies will begin implementing the policies included in the enacted budget. Staff will continue to monitor these polices and provide updates regarding issues that have a significant impact to CalOptima Health. In addition, the Legislature will continue to advance policy bills through the legislative process.

Bills with funding allocated in the enacted budget are more likely to be passed and signed into law. The Legislature has until September 14 to pass legislation, and Gov. Newsom has until October 14 to either sign or veto that legislation.

About CalOptima Health

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

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

CalOptima Health Community Outreach Summary — August and September 2023

Background

CalOptima Health is committed to serving the community by sharing information with current and potential members and strengthening relationships with community partners. To this end, our team attends community coalitions, collaborative meetings and advisory groups as well as supports our community partners' public activities. Participation includes providing Medi-Cal educational materials and, if criteria are met, financial support and/or CalOptima Health-branded items.

CalOptima Health's participation in public activities promotes:

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

Community Outreach Highlight

CalOptima Health partnered with Orange County Supervisors Vicente Sarmiento and Doug Chaffee, the City of Anaheim, and the County of Orange Social Services Agency to spearhead a Medi-Cal renewal awareness campaign on July 29 at Ponderosa Park Family Resource Center in Anaheim. This collaborative effort drew an impressive crowd of approximately 4,200 community members. Attendees gained valuable insights and resources from engagement with Medi-Cal and CalFresh representatives as well as 60 diverse community organizations. Showcasing our commitment to the community's well-being, the event distributed 1,000 boxes of diapers and 2,200 boxes of food. Fun entertainment and family-friendly activities throughout the event made it an enriching experience for all.

Summary of Public Activities

As of August 17, CalOptima Health plans to participate in, organize or convene 87 public activities in August and September. In August, there were 47 public activities, including 18 virtual community/collaborative meetings, eight community-based presentations, 19 community events, one Health Network Forum and one Cafecito meeting. In September, there will be 40 public activities, including 23 virtual community/collaborative meetings, two community-based presentations, 14 community events and one Health Network Forum. A summary of the agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health 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 Health's Policy AA.1214: Guidelines for Endorsements by CalOptima Health, for Letters of Support and Use of CalOptima Health's Name and Logo. More information about policy

requirements can be found at:
https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

For additional information or questions, contact CalOptima Health Community Relations Director Tiffany Kaaiakamanu at 714-222-0637 or tkaaiakamanu@caloptima.org.

Attachment to the
September 7, 2023
CalOptima Health
Outreach Summary

Community events hosted by CalOptima Health and community partners in August and September 2023:

August 2023

August 1, 5–8 p.m., National Night Out, hosted by Garden Grove Police Department
Garden Grove Police Department, 11301 Acacia Pkwy., Garden Grove
- At least two staff members attended (in person).
- Health/resource fair, open to the public.

August 1, 9 a.m.–4 p.m., Unforgettable Conference, hosted by Moving Forward
750 The City Drive South, Ste. 130, Orange
- At least two staff members attended (in person).
- Health/resource fair, open to the public.

August 2, 3–7 p.m., Back to School Family Fair, hosted by Boys & Girls Club of Garden Grove
Kiwanis Land Park, 9840 Larson Ave., Garden Grove
- At least one staff member attended (in person).
- Health/resource fair, open to the public.

August 3, 9–10 a.m., CalOptima Health Medi-Cal Overview in English
U.S .Vets, 1231 Warner Ave., Tustin
- At least one staff member attended (in person).
- Community-based organization presentation, open to members/community.

August 5, 2–5 p.m., Back to School Health Fair, hosted by Northgate Gonzalez Markets
Northgate Market, 1305 W. Whittier Blvd., La Habra
- At least one staff member attended (in person).
- Health/resource fair, open to the public.

August 5, 9 a.m.–1 p.m., Newport-Mesa Unified School District (NMUSD) Family Resource Fair, hosted by NMUSD and Hoag Hospital
IKEA, 1475 S. Coast Dr., Costa Mesa
- At least two staff members attended (in person).
- Health/resource fair, open to the public.

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation
Exhibitor/Attendee

August 8, 9–10 a.m., CalOptima Health Medi-Cal Overview in English
Garden Grove Main Library, 11200 Stanford Ave., Garden Grove

- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community.

August 10, 1–2 p.m., CalOptima Health Medi-Cal Overview in Spanish
Garden Grove Main Library, 11200 Stanford Ave., Garden Grove

- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community.

August 10, 10–11 a.m., CalOptima Health Medi-Cal Overview in English
Olive Community Services (Virtual)

- At least one staff member presented.
- Community-based organization presentation, open to members/community.

August 10, 4:30–6 p.m., Anaheim Mobile Family Resource Fair (FRC), hosted by Neighborhood Human Services
Athena/Sunburst, Anaheim

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

August 12, 9 a.m.–1 p.m., Super Senior Saturday, hosted by City of Buena Park
Buena Park Senior Center, 8150 Knott Ave., Buena Park

- At least one staff member attended (in person).
- Exhibitor Fee: $150; included resource table.
- Health/resource fair, open to the public.

August 15, 4–6 p.m., Back to School Night, hosted by Robert Heideman Elementary School
Robert Heideman Elementary School, 15571 Williams St., Tustin

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

August 15, 4–6:30 p.m., Back to School Night, hosted by W.R. Nelson Elementary School
W.R. Nelson Elementary School, 14392 Browning Ave., Tustin

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation
Exhibitor/Attendee

August 16, 8–10 a.m., Health Care Forum, hosted by Orange County Business Council

Balboa Bay Resort, 1221 W. Coast Highway, Newport Beach

- Sponsorship fee: $7,500; included a half-page ad in event program; logo on marketing and event materials; verbal recognition at event, webpage, and e-newsletter; credit in press release; and table for 10.
- At least 10 staff members attended (in person).
- Health/resource fair, open to the public.

August 17, 10:45–11:45 a.m., CalOptima Health Medi-Cal Overview in English

Brea Senior Center, 500 Sievers Ave., Brea

- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community.

August 17, 1–2 p.m., CalOptima Health Medi-Cal Overview in English

Garden Grove Main Library, 11200 Stanford Ave., Garden Grove

- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community.

August 17, 4:30–6 p.m., Anaheim Mobile FRC, hosted by Neighborhood Human Services

Cabot St., 3239 W. Cabot St., Anaheim

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

August 18, 8–11:30 a.m., Senior Resource Fair, hosted by the Office of Congresswoman Young Kim

Orange Senior Center, 170 S. Olive St., Orange

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

August 18, 2–5 p.m., Back to School Health Fair, hosted by Northgate Gonzalez Markets

Northgate (Santa Ana), 770 S. Harbor Blvd., Santa Ana

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

August 23, 10–11 a.m., CalOptima Health Medi-Cal Overview in English

Fullerton Community Center, 340 W. Commonwealth Ave., Fullerton

- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community.

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

August 23, 9 a.m.–12:30 p.m., Ignite Placentia Health Fair, hosted by Homeless Intervention Services of Orange County (HIS-OC)

Whitten Community Center, 900 S. Melrose St., Placentia

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

August 25, 7:30 a.m.–3:30 p.m., The Annual Southern California Alzheimer's Disease Research Conference, hosted by UCI Institute for Memory Impairments and Neurological Disorders (MIND)

Irvine Airport Hilton,18800 MacArthur Blvd., Irvine

- At least one staff member attended (in person).
- Sponsorship fee: $1,000; included resource table, placement of logo and website link on event website, and signage during event break.
- Health/resource fair, open to the public.

August 26, 9 a.m.–1 p.m., Back-to-School Event, hosted by CalOptima Health

St. Anthony Claret Catholic Church, 1450 E. La Palma Ave., Anaheim

- At least 50 staff members attended (in person).
- Health/resource fair, open to the public.

August 26, 10 a.m.–4 p.m., Multicultural Maternal Health Expo, hosted by HerStory

Midway Community Center, 14900 Park Ln., Midway City

- Sponsorship fee: $1,000; included marketing materials in attendee bag, two-hour custom package, and 30-minute follow-up session.
- At least one staff member attended (in person).
- Health/resource fair, open to the public.

August 27, 11 a.m.–3 p.m., Multicultural Maternal Health Expo, hosted by HerStory

Midway Community Center, 14900 Park Ln., Midway City

- Sponsorship fee: $1,000; included marketing materials in attendee bag, two-hour custom package, and 30-minute follow-up session.
- At least one staff member attended (in person).
- Health/resource fair, open to the public.

August 29, 9–10:30 a.m., Cafecito Meeting

Virtual

- At least nine staff members attended.
- Steering committee meeting, open to collaborative members.

August 30, 10–11 a.m., CalOptima Health Medi-Cal Overview in English

Laura’s House, Virtual

- At least one staff member presented.
- Community-based organization presentation, open to members/community.

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation Exhibitor/Attendee

August 31, 8 a.m.–4:30 p.m., Health Clinic, hosted by St. Jude's Ministry

St. Jude Heritage Medical Clinic, 4300 Rose Dr., Yorba Linda

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

September 2023

September 1, Gift of History, hosted by Children's Education Foundation of Orange County

Sponsorship fee: $3,500; includes one full page of CalOptima Health information and QR codes on the back pages of "Nothing Rhymes with Orange" book, to be shared with 30,000 Orange County third graders; CalOptima Health's logo will be displayed on partner's website.

September 5, 10–11a.m., CalOptima Health Medi-Cal Overview in English

Families Forward, Virtual

- At least one staff member presented.
- Community-based organization presentation, open to members/community.

September 7, 10 a.m.–1 p.m., Annual Health Fair, hosted by the Orange County Employees Association (OCEA)

OCEA Headquarters, 830 N. Ross St., Santa Ana

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

September 7, 10:30 a.m.–1:30 p.m., Community Agency Resource Fair, hosted by Garden Grove Unified School District

Garden Grove Unified School District, 10331 Stanford Ave., Garden Grove

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

September 7, 5–7 p.m., Resource Evenings, hosted by Phoenix Arise

Parochial Hall, 120 N. Janns St., Anaheim

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

September 9, 11 a.m.–2 p.m., Caring for Caregivers Resource Fair, hosted by the Office of Congressman Lou Correa

Downtown Anaheim Community Center, 250 E. Center St., Anaheim

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

September 12, 10 a.m.–Noon, Back to School Bash, hosted by the Office of Council Member Carlos Leon

Madison Elementary School, 1510 S. Nutwood St., Anaheim

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

September 12, 5–7 p.m., Super Senior Saturday, hosted by City of Buena Park

Buena Park Senior Center, 8150 Knott Ave. Buena Park

- Registration fee: $150; includes resource table at event.
- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

September 13, 9:30–10:30 a.m., CalOptima Health Medi-Cal Overview in Spanish

Whitten Community Center, 900 S. Melrose St., Placentia

- At least one staff member to present (in person).
- Community-based organization presentation, open to members/community.

September 14, 11 a.m.–2 p.m., Health and Community Resource Fair, hosted by United Domestic Workers of America

Santa Ana Zoo, 1801 E. Chestnut Ave., Santa Ana

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

September 16, 10 a.m.–1 p.m., Active Living Expo, hosted by Huntington Beach Council on Aging

Senior Center in Central Park, 18041 Goldenwest St., Huntington Beach

- Sponsorship fee: $1,000; includes resource table, agency's name displayed on event banner, a half-page ad in event program, recognition from the Main Stage during event, link to agency's website from the host website for six months, placement of agency's name/logo on banners to be placed around the senior center for two weeks prior to the event, logo on event's Passport to Health, agency's banner showcased in prominent area of the senior center the week before the event, and a Press Release from City of Huntington Beach.
- At least one staff member to attend (in person).
- Health/resource fair, open to the public

September 16, 10 a.m.–2:30 p.m., Mental Health Summit, hosted by Big Brothers Big Sisters of Orange County

Samueli Academy, 1901 N. Fairview St., Santa Ana

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

September 20, 10 a.m.–1 p.m., H. Louis Lake Senior Center Resource Fair, hosted by H. Louis Lake Senior Center

Community Meeting Center, 11300 Stanford Ave., Garden Grove

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

September 27, 10 a.m.–1 p.m., Knowledge and Health Fair Expo, hosted by Costa Mesa Senior Center

Costa Mesa Senior Center, 695 W. 19th St., Costa Mesa

- Registration fee: $250; includes resource table, table sign displaying organization's name, and name on passport.
- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

September 30, 3–8:30 p.m., Mid-Autumn Children's Festival, hosted by Nguoi Viet

Atlantis Play Center, 13630 Atlantis Way., Garden Grove

- Sponsorship fee: $2,500; resource table at event, weekly promotion on Facebook page, multiple acknowledgments by MCs during stage program, on-stage recognition with special gift from the organizer, newspaper, radio and TV ad impressions, one-minute remarks to festival attendees on stage during the opening ceremony, logo prominently featured on event t-shirt, additional banner placement throughout the festival.
- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

These sponsorship request(s) and community event(s) met the requirements of CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at:
https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
10. Election of Officers of the Board of Directors for Fiscal Year 2023-24

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

Recommended Action
~~Elect~~ Extend the current Board Chair and Vice Chair until the November 2, 2023 Board of Directors meeting. ~~for terms effective September 7, 2023 through June 30, 2024, or until the election of a successor(s), unless the Board Chair or Vice Chair shall sooner resign or be removed from office.~~

Rev. 9/7/2023

Background/Discussion
In accordance with Article VIII, Section 8.1 of CalOptima Health's Bylaws, the Board shall elect one of its Directors as Chair at an organizational meeting. The Chair shall be the principal officer of the Board, shall preside at all meetings of the Board, and shall appoint all members of the Ad Hoc Committees, as well as the chair of the Ad Hoc Committees and all Committees other than the Member and Provider Advisory Committees. The Chair shall perform all duties incident to the office and such other duties as may be prescribed by the Board from time to time.

Section 8.2 of the CalOptima Health Bylaws states that the Board shall elect one of its Directors to serve as Vice Chair at an organizational meeting. The Vice Chair shall perform the duties of the Chair if the Chair is absent from the meeting or is otherwise unable to act.

The Chair and Vice Chair terms shall commence on the first day of the month after the organizational meeting at which they are elected to their respective positions.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The recommended actions are in accordance with Article VIII of the CalOptima Health Bylaws.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
None

/s/ Michael Hunn *08/31/2023*
Authorized Signature **Date**

CalOptima Health Board Action Agenda Referral

Action To Be Taken September 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
11. Approve Modifications to CalOptima Health Board-Designated Reserve Funds Policy

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

Recommended Action
Approve modifications to CalOptima Health Policy GA.3001: Board-Designated Reserve Funds.

Background
CalOptima Health regularly reviews its policies and procedures to ensure they are up to date and align with federal and state health care program requirements, contractual obligations, laws, and CalOptima Health operations.

Discussion
The table below outlines a list of substantive changes to CalOptima Health Policy GA.3001: Board-Designated Reserve Funds (Policy), which are reflected in the attached redline policy. The list excludes non-substantive changes that may also be reflected in the redline (*e.g.*, formatting, spelling, punctuation, capitalization, minor clarifying language, and/or grammatical changes).

CalOptima Health last revised the Policy on December 3, 2015. The Policy provides guidance on the creation, maintenance, and utilization of reserve funds to ensure long-term financial viability.

Section	Proposed Change	Rationale
II.A.	Clarify that the minimum threshold does not constitute a mandate to draw reserves down to that level and the Board's discretion on the appropriate reserve level.	To clarify Board governance over reserves.
II.B.2.c.	Exclude Managed Care Organization (MCO) tax from the calculation of one month's consolidated capitation revenue.	Reflect current methodology.
II.C.2.	Add Board review of levels of total assets and reserve funds on an annual basis, at minimum, and include an assessment of resources to be used for the purposes identified in County ordinance.	Enhance CalOptima Health's governance over total assets.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2023-24 Operating Budget.

Rationale for Recommendation

Back to Agenda

Updates to the Policy will promote fiscal prudence, sound stewardship of public funds, and improve CalOptima Health's short-term and long-term financial viability.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Health Policy GA.3001: Board-Designated Reserve Funds

/s/ Michael Hunn *08/31/2023*
Authorized Signature **Date**

Back to Agenda

Policy:	GA.3001
Title:	**Board-Designated Reserve Funds**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	11/01/1996
Revised Date:	07/01/2023
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

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

II. POLICY

A. ~~It shall be the goal of CalOptima~~CalOptima Health's goal is to maintain Board-designated reserve funds of no less than one point four (1.4) months' consolidated capitation revenues and no more than two (2.0) months' consolidated capitation revenues. Additional goals for the creation of Board-designated reserve funds shall be approved by the ~~CalOptima~~CalOptima Health Board of Directors (Board), as deemed necessary by management and the Board.~~-~~ This is a minimum threshold and not a mandate to draw reserves down to this level. The Board shall have discretion on the appropriate reserve level~~,~~ above the minimum threshold, taking into account current and future economic conditions.

B. Creation of Board-Designated Reserve Funds

1. Existing Reserves

   a. Working capital deficits shall be subtracted from reserves.

2. Creation of New Reserves

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

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

Back to Agenda Back to Item

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

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

C. Purpose and Utilization of Existing Reserves

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

2. The Board shall review levels of total assets and Board-designated reserve funds, at the minimum, on an annual basis, including, but not limited to, during the development of the strategic plan and the preparation of the annual operating budget. As part of this review, the Board shall assess resources to be used for the purposes of expanding access to care, improving member benefits, and/or augmenting provider reimbursement, in accordance with Title 4, Division 11 of the Codified Ordinances of the County of Orange, California.

~~2.~~3. Utilization of existing reserves during a delay in capitation revenues from the State.

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

b. If the delay in ~~CalOptima~~CalOptima Health's receipt of capitation revenues from the State exceeds two (2.0) months, or the amount of Board-designated reserve funds falls below the range set forth in Section III.A., ~~CalOptima~~CalOptima Health staff may propose actions to the Board to ensure financial stability for ~~CalOptima~~CalOptima Health and its Providers and vendors.

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

~~3.~~4. Except as authorized in Section II.C.~~2~~3.a. of this policy, any withdrawals from Board-designated reserve funds shall be approved by the Board through the annual Budget process, or through a separate action approved by the Board at a regular or special meeting of the Board. The Budget is ~~CalOptima~~CalOptima Health's Board-approved annual operating Budget that incorporates net available for reserves.

~~4.~~5. The Board, through approval of a Board Action Request, may specifically designate all or a portion of Board-designated reserve funds for one (1) or more Special Purposes at any time. A

Back to Agenda Back to Item

Special Purpose is a specifically designated use, as determined solely by the Board, that best addresses a programmatic or financial need facing ~~CalOptima~~CalOptima Health. The Board may also remove or modify any or all such specific designations previously imposed through approval of a subsequent Board Action Request.

~~5.~~6. ~~CalOptima~~CalOptima Health management shall notify the Board of all uses of Board-designated reserve funds, regardless of prior approval requirements set forth in this policy.

~~6.~~7. On an annual basis, the Board may review this policy concurrently with the approval of the annual operating budget.

III. PROCEDURE

A. Transfers to or from Board-Designated Reserve Funds

1. Prior to the end of each month, ~~CalOptima~~CalOptima Health's Chief Financial Officer (CFO), Chief Executive Officer (CEO), or designee, shall instruct the Controller, or his or her designee, to transfer a specified dollar amount into or from ~~CalOptima~~CalOptima Health's Board-designated reserve funds (from or to ~~CalOptima~~CalOptima Health's operating funds). Said transfer shall be consistent with either the Board's approved Budget or a subsequently approved Board Action Request.

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

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

C. In accordance with Section II.C.~~4~~5. of this policy, ~~CalOptima~~CalOptima Health management shall, upon its own initiative or the request of the Board, prepare and submit a Board Action Request to specifically designate, for one (1) or more Special Purposes, all or a portion of the Board-designated reserve funds. If the Board approves such Board Action Request, management shall ~~so~~ describe the specific designations of such funds on subsequent ~~CalOptima~~CalOptima Health balance sheets. The subsequent removal or modification of a previously approved specific designation of Board-designated reserve funds shall follow the same process as that utilized for creating the original designation. If the Board subsequently approves the removal or modification of a specific designation, management shall appropriately adjust future ~~CalOptima~~CalOptima Health balance sheets to properly account for such removal or modification.

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

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/06/2000	Regular Meeting of the CalOptima Board of Directors
03/01/2012	Regular Meeting of the CalOptima Board of Directors
06/06/2013	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1996	GA.3001	Board-Designated Reserve Funds	Administrative
Revised	06/2000	GA.3001	Board-Designated Reserve Funds	Administrative
Revised	06/01/2007	GA.3001	Board-Designated Reserve Funds	Administrative
Revised	03/01/2012	GA.3001	Board-Designated Reserve Funds	Administrative
Revised	06/06/2013	GA.3001	Board-Designated Reserve Funds	Administrative
Revised	12/03/2015	GA.3001	Board-Designated Reserve Funds	Administrative
Revised	09/01/2016	GA.3001	Board-Designated Reserve Funds	Administrative
Revised	07/01/2023	GA.3001	Board-Designated Reserve Funds	Administrative

IX. GLOSSARY

Not Applicable

Policy:	GA.3001
Title:	**Board-Designated Reserve Funds**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	11/01/1996
Revised Date:	07/01/2023
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

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

II. POLICY

A. CalOptima Health's goal is to maintain Board-designated reserve funds of no less than one point four (1.4) months' consolidated capitation revenues and no more than two (2.0) months' consolidated capitation revenues. Additional goals for the creation of Board-designated reserve funds shall be approved by the CalOptima Health Board of Directors (Board), as deemed necessary by management and the Board. This is a minimum threshold and not a mandate to draw reserves down to this level. The Board shall have discretion on the appropriate reserve level above the minimum threshold, taking into account current and future economic conditions.

B. Creation of Board-Designated Reserve Funds

1. Existing Reserves

a. Working capital deficits shall be subtracted from reserves.

2. Creation of New Reserves

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

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

c. For purposes of this policy, one (1) month's consolidated capitation revenues is calculated based on the average consolidated capitation revenue excluding special pass-through payments such as Quality Assurance Fees (QAF), Managed Care Organization (MCO) tax,

Back to Agenda Back to Item

and Intergovernmental transfers (IGT) or prior year rate adjustments implemented in the current year during the most recent twelve (12) month period for which all capitation payments have been received by CalOptima Health, and for which internally-prepared financial statements are available.

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

C. Purpose and Utilization of Existing Reserves

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

2. The Board shall review levels of total assets and Board-designated reserve funds, at the minimum, on an annual basis, including, but not limited to, during the development of the strategic plan and the preparation of the annual operating budget. As part of this review, the Board shall assess resources to be used for the purposes of expanding access to care, improving member benefits, and/or augmenting provider reimbursement, in accordance with Title 4, Division 11 of the Codified Ordinances of the County of Orange, California.

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

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

b. If the delay in CalOptima Health's receipt of capitation revenues from the State exceeds two (2.0) months, or the amount of Board-designated reserve funds falls below the range set forth in Section III.A., CalOptima Health staff may propose actions to the Board to ensure financial stability for CalOptima Health and its Providers and vendors.

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

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

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

Back to Agenda Back to Item

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

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

III. PROCEDURE

A. Transfers to or from Board-Designated Reserve Funds

1. Prior to the end of each month, CalOptima Health's Chief Financial Officer (CFO), Chief Executive Officer (CEO), or designee, shall instruct the Controller, or his or her designee, to transfer a specified dollar amount into or from CalOptima Health's Board-designated reserve funds (from or to CalOptima Health's operating funds). Said transfer shall be consistent with either the Board's approved Budget or a subsequently approved Board Action Request.

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

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

C. In accordance with Section II.C.5. of this policy, CalOptima Health management shall, upon its own initiative or the request of the Board, prepare and submit a Board Action Request to specifically designate, for one (1) or more Special Purposes, all or a portion of the Board-designated reserve funds. If the Board approves such Board Action Request, management shall describe the specific designations of such funds on subsequent CalOptima Health balance sheets. The subsequent removal or modification of a previously approved specific designation of Board-designated reserve funds shall follow the same process as that utilized for creating the original designation. If the Board subsequently approves the removal or modification of a specific designation, management shall appropriately adjust future CalOptima Health balance sheets to properly account for such removal or modification.

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

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Back to Agenda Back to Item

Date	Meeting
06/06/2000	Regular Meeting of the CalOptima Board of Directors
03/01/2012	Regular Meeting of the CalOptima Board of Directors
06/06/2013	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1996	GA.3001	Board-Designated Reserve Funds	Administrative
Revised	06/2000	GA.3001	Board-Designated Reserve Funds	Administrative
Revised	06/01/2007	GA.3001	Board-Designated Reserve Funds	Administrative
Revised	03/01/2012	GA.3001	Board-Designated Reserve Funds	Administrative
Revised	06/06/2013	GA.3001	Board-Designated Reserve Funds	Administrative
Revised	12/03/2015	GA.3001	Board-Designated Reserve Funds	Administrative
Revised	09/01/2016	GA.3001	Board-Designated Reserve Funds	Administrative
Revised	07/01/2023	GA.3001	Board-Designated Reserve Funds	Administrative

Back to Agenda Back to Item

IX. GLOSSARY

Not Applicable

CalOptima Health Board Action Agenda Referral

Action To Be Taken September 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
12. Approve Modifications to CalOptima Health Office of Compliance Policy HH.3012: Non-Retaliation for Reporting Violations

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

Recommended Actions
Approve updated Office of Compliance Policy HH.3012: Non-Retaliation for Reporting Violations.

Background
Policy HH.3012: Non-Retaliation for Reporting Violations reinforces CalOptima Health's commitment to compliance with applicable laws, regulations, and policies. It also reflects CalOptima Health's policy against intimidation, harassment, discrimination, or any other retaliatory action against individuals who report, or seek guidance related to, suspected or actual non-compliance with laws and regulations, or unethical conduct.

Discussion
The primary change to this policy is to add language noting that CalOptima Health will conduct an anonymous employee survey on an annual basis in order to assess whether employees understand how to report suspected or actual fraud, waste, and abuse; violations of applicable laws and regulations, CalOptima Health policies, or potential misconduct; and whether they feel comfortable doing so. This change is in response to a recommendation in the California State Auditor's (CSA) audit. The first annual survey was conducted from March 31 through April 21, 2023. Other changes to the policy were minor, clarifying changes to the existing language.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the Fiscal Year 2023-24 Operating Budget.

Rationale for Recommendation
The change to the policy documents implementation of the CSA recommendation.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations

/s/ Michael Hunn *08/31/2023*
Authorized Signature **Date**

Back to Agenda

Policy:	HH.3012
Title:	**Non-Retaliation for Reporting Violations**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	07/01/2023
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy reinforces CalOptima Health's commitment to compliance with applicable laws, regulations, and policies and its policy against intimidation, harassment, discrimination, or any other retaliatory action against individuals who report, or seek guidance related to, suspected or actual non-compliance with such laws and regulations, or unethical conduct.

II. POLICY

A. CalOptima Health, its Governing Body members, Employees, Contractors, and First Tier, Downstream, and Related Entities (FDRs) shall not threaten, intimidate, coerce, harass, discriminate, or otherwise Retaliate against individuals who report, or file complaints related to, suspected or actual non-compliance with applicable laws, regulations, or policies (including, without limitation, Health Insurance Portability and Accountability Act (HIPAA), the False Claims Act, and other laws) and/or related to unethical conduct.

B. CalOptima Health, its Governing Body members, Employees, Contractors, and FDRs shall not be subject to retaliatory action or discrimination by CalOptima Health for reporting, in good faith, suspected or actual non-compliance or unethical conduct, or for participating in any investigation.

C. CalOptima Health, its Governing Body members, Employees, Contractors, and FDRs shall not Retaliate for:

1. The exercise of any right under, or participating in, any process established by federal, state, or local law, regulations, or policy, including but not limited to filing a Complaint with CalOptima Health and/or the United States Department of Health and Human Services relating to privacy;

2. Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing; or

3. Opposing any act or practice made unlawful by law, provided that the person has a good faith belief that the practice is unlawful, and the manner of the opposition is reasonable and does not involve a Disclosure of Protected Health Information (PHI) in violation of law and policies.

D. CalOptima Health, its Governing Body members, Employees, Contractors, and FDRs shall immediately report any action believed to be Retaliation or discrimination against any individual for

Back to Agenda Back to Item

reporting suspected or actual non-compliance with laws, unethical conduct, or wrongdoing, or for participating in any investigation, in accordance with Section III.B. of this Policy.

E. CalOptima Health shall provide guidance, in accordance with CalOptima Health Policy HH.2018: Compliance and Ethics Hotline, on how ~~an~~ Employees, Contractors, members of the Governing Body, FDRs, or Members may anonymously report potential non-compliance and Fraud, Waste, and Abuse (FWA) issues to the extent permitted by applicable law and circumstances.

F. CalOptima Health does not tolerate intimidation, coercion, harassment, discrimination, or other forms of Retaliation towards individuals who report suspected or actual non-compliance or unethical conduct. Individuals or entities determined to have violated CalOptima Health's non-Retaliation policy will be subject to disciplinary and/or other corrective action, up to and including termination.

III. PROCEDURE

A. CalOptima Health shall protect against any Retaliation toward an Employee, Contractor, member of the Governing Body, FDR, or Member by ensuring all verbal, or written, reports, made in good faith, remain Confidential to the extent allowable by law.

B. CalOptima Health shall maintain Confidential methods for Employees, Contractors, members of the Governing Body, FDRs, or Members to report suspected violations of policy, rules, and regulations through any of the following options~~by~~:

1. Anonymously reporting issues twenty-four (24) hours a day, seven (7) days a week to the:

   Compliance and Ethics Hotline at 1-855-507-1805;

   ~~Calling the Compliance and Ethics Hotline, toll-free, twenty-four (24) hours a day, seven (7) days a week~~

2. Reporting directly to the CalOptima Health Chief Compliance Officer;

3. Sending an email to: compliance@caloptima.org;

4. For Employees, completing a Regulatory Affairs & Compliance Intake Form (available on the CalOptima Health InfoNet); or

5. Completing a Suspected Fraud or Abuse Referral Form (available on the CalOptima Health website).

C. CalOptima Health and the Office of Compliance shall ensure Employees, Contractors, members of the Governing Body, FDRs, or Members are informed of CalOptima Health's non-Retaliation policy by posting information on the CalOptima Health InfoNet and website, as well as sending periodic Member notifications.

D. It is the responsibility of all CalOptima Health Employees, Contractors, members of the Governing Body, and FDRs to report, in good faith, perceived or known misconduct, in accordance with CalOptima Health Policy HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Health Policies.

E. Knowledge of a violation, or potential violation, of this Policy shall be reported directly to the Chief Compliance Officer, or to the Compliance and Ethics Hotline.

F. Failure of a CalOptima Health Employee to report any such violation, or possible violation, may be grounds for disciplinary action.

G. In order to assess whether Employees- understand how to report suspected or actual Fraud, Waste, or Abuse (FWA), violations of applicable laws and regulations, CalOptima Health Policies, or potential misconduct and whether they feel comfortable doing so, CalOptima Health will conduct or contract for an anonymous survey of ~~staff~~Employees on an annual basis. The survey will be conducted as a standalone survey or incorporated into another anonymous Eemployee survey when reasonable.

IV. ATTACHMENT(S)

A. RAC Intake Form
B. Suspected Fraud or Abuse Referral Form

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
E. CalOptima Health Policy HH.2018: Compliance and Ethics Hotline
F. CalOptima Health Policy HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Health Policies
G. False Claims Act (31 U.S.C. §3730(h))
H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9
J. Title 42, Code of Federal Regulations (CFR.), §455.2
K. Title 45, Code of Federal Regulations (CFR.), §§164.530(g) and 160.316
L. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/19/2012	Department of Managed Health Care (DMHC)	Approved as Submitted
07/02/2013	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

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

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2002	MA.9223	Reporting Non-Intimidation and Non-Retaliation	OneCare
Effective	04/01/2003	HH.3012	Prohibition on Retaliation on Reporting Violations to Privacy Policies and Procedures	Medi-Cal
Revised	11/01/2004	MA.9223	Reporting Non-Intimidation and Non-Retaliation	OneCare
Revised	04/01/2007	HH.3012	Prohibition on Retaliation on Reporting Violations to Privacy Policies and Procedures	Medi-Cal
Revised	07/01/2007	MA.9223	Reporting Non-Intimidation and Non-Retaliation	OneCare
Revised	01/01/2010	MA.9223	Reporting Non-Intimidation and Non-Retaliation	OneCare
Revised	02/01/2012	HH.3012	Non-Retaliation for Reporting Violation	Medi-Cal
Revised	02/01/2013	HH.3012Δ	Non-Retaliation for Reporting Violation	Medi-Cal OneCare
Revised	09/01/2014	MA.9223	Reporting Non-Intimidation and Non-Retaliation	OneCare
Revised	09/01/2015	HH.3012	Non-Retaliation for Reporting Violation	Medi-Cal
Revised	09/01/2015	MA.9223	Non-Retaliation for Reporting Violation	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3012Δ	Non-Retaliation for Reporting Violation	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9223	Non-Retaliation for Reporting Violation	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3012Δ	Non-Retaliation for Reporting Violation	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3012Δ	Non-Retaliation for Reporting Violation	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3012Δ	Non-Retaliation for Reporting Violation	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3012Δ	Non-Retaliation for Reporting Violation	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3012Δ	Non-Retaliation for Reporting Violation	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	12/31/2022	HH.3012	Non-Retaliation for Reporting Violation	Medi-Cal OneCare PACE
Revised	07/01/2023	HH.3012	Non-Retaliation for Reporting Violation	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Health Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Confidential	Entrusted with private or personal information that is confined to a person or group as opposed to the public.
Disclosure	Has the meaning in in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health program benefit, below the level of the arrangement between CalOptima Health and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	For purposes of this policy, any and all employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary (contract) employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a member under a CalOptima Health program.
Fraud	~~artifice~~ Artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C Section 1347).
Governing Body	The Board of Directors of CalOptima Health.
Member	A beneficiary enrolled in a CalOptima Health Program.

Term	Definition
Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Related Entity	Any entity that is related to CalOptima Health by common ownership or control and that: performs some of CalOptima Health's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima Health at a cost of more than $2,500 during a contract period.
Retaliation (or Retaliate)	Includes, but is not limited to, coercion, threats, harassment, intimidation, discrimination, and other forms of retaliatory action against individuals.
Waste	Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Policy:	HH.3012
Title:	**Non-Retaliation for Reporting Violations**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	07/01/2023
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy reinforces CalOptima Health's commitment to compliance with applicable laws, regulations, and policies and its policy against intimidation, harassment, discrimination, or any other retaliatory action against individuals who report, or seek guidance related to, suspected or actual non-compliance with such laws and regulations, or unethical conduct.

II. POLICY

A. CalOptima Health, its Governing Body members, Employees, Contractors, and First Tier, Downstream, and Related Entities (FDRs) shall not threaten, intimidate, coerce, harass, discriminate, or otherwise Retaliate against individuals who report, or file complaints related to, suspected or actual non-compliance with applicable laws, regulations, or policies (including, without limitation, Health Insurance Portability and Accountability Act (HIPAA), the False Claims Act, and other laws) and/or related to unethical conduct.

B. CalOptima Health, its Governing Body members, Employees, Contractors, and FDRs shall not be subject to retaliatory action or discrimination by CalOptima Health for reporting, in good faith, suspected or actual non-compliance or unethical conduct, or for participating in any investigation.

C. CalOptima Health, its Governing Body members, Employees, Contractors, and FDRs shall not Retaliate for:

1. The exercise of any right under, or participating in, any process established by federal, state, or local law, regulations, or policy, including but not limited to filing a Complaint with CalOptima Health and/or the United States Department of Health and Human Services relating to privacy;

2. Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing; or

3. Opposing any act or practice made unlawful by law, provided that the person has a good faith belief that the practice is unlawful, and the manner of the opposition is reasonable and does not involve a Disclosure of Protected Health Information (PHI) in violation of law and policies.

D. CalOptima Health, its Governing Body members, Employees, Contractors, and FDRs shall immediately report any action believed to be Retaliation or discrimination against any individual for

Back to Agenda Back to Item

reporting suspected or actual non-compliance with laws, unethical conduct, or wrongdoing, or for participating in any investigation, in accordance with Section III.B. of this Policy.

E. CalOptima Health shall provide guidance, in accordance with CalOptima Health Policy HH.2018: Compliance and Ethics Hotline, on how Employees, Contractors, members of the Governing Body, FDRs, or Members may anonymously report potential non-compliance and Fraud, Waste, and Abuse (FWA) issues to the extent permitted by applicable law and circumstances.

F. CalOptima Health does not tolerate intimidation, coercion, harassment, discrimination, or other forms of Retaliation towards individuals who report suspected or actual non-compliance or unethical conduct. Individuals or entities determined to have violated CalOptima Health's non-Retaliation policy will be subject to disciplinary and/or other corrective action, up to and including termination.

III. PROCEDURE

A. CalOptima Health shall protect against any Retaliation toward an Employee, Contractor, member of the Governing Body, FDR, or Member by ensuring all verbal, or written, reports, made in good faith, remain Confidential to the extent allowable by law.

B. CalOptima Health shall maintain Confidential methods for Employees, Contractors, members of the Governing Body, FDRs, or Members to report suspected violations of policy, rules, and regulations through any of the following options:

1. Anonymously reporting issues twenty-four (24) hours a day, seven (7) days a week to the:

   Compliance and Ethics Hotline at 1-855-507-1805;

2. Reporting directly to the CalOptima Health Chief Compliance Officer;

3. Sending an email to: compliance@caloptima.org;

4. For Employees, completing a Regulatory Affairs & Compliance Intake Form (available on the CalOptima Health InfoNet); or

5. Completing a Suspected Fraud or Abuse Referral Form (available on the CalOptima Health website).

C. CalOptima Health and the Office of Compliance shall ensure Employees, Contractors, members of the Governing Body, FDRs, or Members are informed of CalOptima Health's non-Retaliation policy by posting information on the CalOptima Health InfoNet and website, as well as sending periodic Member notifications.

D. It is the responsibility of all CalOptima Health Employees, Contractors, members of the Governing Body, and FDRs to report, in good faith, perceived or known misconduct, in accordance with CalOptima Health Policy HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Health Policies.

E. Knowledge of a violation, or potential violation, of this Policy shall be reported directly to the Chief Compliance Officer, or to the Compliance and Ethics Hotline.

F. Failure of a CalOptima Health Employee to report any such violation, or possible violation, may be grounds for disciplinary action.

G. In order to assess whether Employees understand how to report suspected or actual Fraud, Waste, or Abuse (FWA), violations of applicable laws and regulations, CalOptima Health Policies, or potential misconduct and whether they feel comfortable doing so, CalOptima Health will conduct or contract for an anonymous survey of Employees on an annual basis. The survey will be conducted as a standalone survey or incorporated into another anonymous Employee survey when reasonable.

IV. ATTACHMENT(S)

A. RAC Intake Form
B. Suspected Fraud or Abuse Referral Form

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
E. CalOptima Health Policy HH.2018: Compliance and Ethics Hotline
F. CalOptima Health Policy HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Health Policies
G. False Claims Act (31 U.S.C. §3730(h))
H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9
J. Title 42, Code of Federal Regulations (CFR.), §455.2
K. Title 45, Code of Federal Regulations (CFR.), §§164.530(g) and 160.316
L. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/19/2012	Department of Managed Health Care (DMHC)	Approved as Submitted
07/02/2013	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

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

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2002	MA.9223	Reporting Non-Intimidation and Non-Retaliation	OneCare

Back to Agenda Back to Item

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3012	Prohibition on Retaliation on Reporting Violations to Privacy Policies and Procedures	Medi-Cal
Revised	11/01/2004	MA.9223	Reporting Non-Intimidation and Non-Retaliation	OneCare
Revised	04/01/2007	HH.3012	Prohibition on Retaliation on Reporting Violations to Privacy Policies and Procedures	Medi-Cal
Revised	07/01/2007	MA.9223	Reporting Non-Intimidation and Non-Retaliation	OneCare
Revised	01/01/2010	MA.9223	Reporting Non-Intimidation and Non-Retaliation	OneCare
Revised	02/01/2012	HH.3012	Non-Retaliation for Reporting Violation	Medi-Cal
Revised	02/01/2013	HH.3012Δ	Non-Retaliation for Reporting Violation	Medi-Cal OneCare
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Revised	07/01/2023	HH.3012	Non-Retaliation for Reporting Violation	Medi-Cal OneCare PACE

IX. GLOSSARY

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1

REGULATORY AFFAIRS AND COMPLIANCE (RAC) INTAKE FORM

INSTRUCTIONS

Please complete this form in its entirety. Be sure to attach all relevant documents (e.g., P&P, contract language excerpts, regulations etc.), and use concise explanations to support the basis of your request. Processing the request will be delayed if supporting documentation is not initially provided or if this form is incomplete.

Requestor must submit the completed form via email at compliance@caloptima.org or via hard copy to CalOptima Health, Attn: Compliance Officer, 505 City Parkway West, Orange CA 92868.

*If you would like to report your concern anonymously, please do so by calling the Compliance & Ethics Hotline at 1-**855-507-1805.***

SECTION 1: GENERAL INFORMATION

DATE:	**ORGANIZATION/DEPT:**
REQUESTOR'S NAME:	**PHONE / EMAIL:**

SECTION 2: SELECT TYPE OF REQUEST — Request for Action OR Request for Guidance

REQUEST FOR ACTION (RFA)

Complete this section if you are **reporting an issue of non- compliance**, for example:

- You believe that a CalOptima Health department or delegate violated a policy, contract or regulatory obligation.
- You need to report that a process or individual is preventing a member's access to care.

If this is a Medi-Cal member billing concern, you must also complete the Member Billing form, linked here. This document must accompany the RAC Intake Form in order to process member billing concerns.

An acknowledgment notice will be sent to you within five business days from the date the complete request is received in the RAC department. A final response will be sent when the investigation concludes. Investigations vary in length.

Explain in detail the suspected issue of non-compliance. Specify what standard or requirement has been violated. Please attach another page if more room is needed. If applicable, provide a proposed solution, answer or suggestions.

Date(s) of Incident:

Detailed Description of Issue:

REQUEST FOR GUIDANCE (RFG)

Complete this section if you would like to **ask a question or need regulatory guidance**, such as:

- You are requesting interpretation of a CalOptima Health policy, regulatory contract or regulatory requirement.
- You are requesting assistance in identifying a regulatory requirement.

An acknowledgment notice will be sent to you within five business days from the date the complete request is received in the RAC department. All requests will be responded to within three weeks from the date the complete request is received in the RAC department.

Provide a short specific background statement (factual details) to assist RAC in fully understanding the basis of the question. If applicable, provide a proposed solution, answer or suggestions.

Specific Question to be Answered:

Background Information:

REGULATORY AFFAIRS AND COMPLIANCE (RAC) INTAKE FORM

SECTION 3: BASIS FOR THE REQUEST

Program(s) Impacted (if applicable): ☐ Medi-Cal ☐ OneCare ☐ PACE

Identify resources consulted and other information (please include them as part of your request):

☐ **CONTRACT**

Title of Contract:

Section(s) of the Contract:

☐ **CALOPTIMA HEALTH POLICY**

Policy #(s):

Section(s) of the Policy:

☐ **SUB-REGULATORY GUIDANCE**

Type of Guidance (i.e., All Plan Letter (APL); Duals Plan Letter (DPL) or CMS guidance, such as HPMS Memo):

Guidance Title and Section/Pg. #:

OTHER:

☐ Statute/Regulation:

☐ Business Associate Agreement:

☐ Regulatory Audit:

☐ NCQA:

☐ Other:

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CalOptima Health

INSTRUCTIONS FOR COMPLETING A SUSPECTED FRAUD OR ABUSE REFERRAL FORM

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

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

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

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

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

MARK ALL CORRESPONDENCE AS "CONFIDENTIAL."

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

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CalOptima Health

SUSPECTED FRAUD OR ABUSE REFERRAL FORM

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

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

Examples of suspected fraud or abuse:

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

Allegation of suspected fraud or abuse:

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

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CalOptima Health

SUSPECTED FRAUD OR ABUSE REFERRAL FORM

	☐ Failure to disclose conflict of interest ☐ Receiving, soliciting or offering a kickback, bribe or rebate to refer or fail to refer a member ☐ Failure to register billing intermediary with the Department of Health Care Services (DHCS) ☐ False certification of medical necessity ☐ Attributing a diagnosis code to a member that does not reflect the member's medical condition to obtain higher reimbursement ☐ False or inaccurate Minimum Standards or credentialing information ☐ Submitting reports that contain unsubstantiated data, data that is inconsistent with records or has been altered in a manner that is inconsistent with policies, contracts, statutes or regulations. ☐ Other (please specify) _____

DOCUMENTATION (PLEASE ATTACH):

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

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

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

OTHER RELEVANT INFORMATION (PLEASE ATTACH):

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

1. ☐ No
   ☐ Yes. Please describe:

2. If yes, what was the outcome?

Please submit this form with all pertinent documentation to the OFFICE OF COMPLIANCE SPECIAL INVESTIGATIONS UNIT (SIU). The Office of Compliance SIU shall report as appropriate to local and state entities. If you do not receive an acknowledgement of receipt of this form within five (5) working days, please send an email to Fraud@CalOptima.org.

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SUSPECTED FRAUD OR ABUSE REFERRAL FORM

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

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

Examples of suspected fraud or abuse:

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

Allegation of suspected fraud or abuse:

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

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CalOptima Health

SUSPECTED FRAUD OR ABUSE REFERRAL FORM

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

DOCUMENTATION (PLEASE ATTACH):

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

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

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

OTHER RELEVANT INFORMATION (PLEASE ATTACH):

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

1. ☐ No
   ☐ Yes. Please describe:

2. If yes, what was the outcome?

Please submit this form with all pertinent documentation to the OFFICE OF COMPLIANCE SPECIAL INVESTIGATIONS UNIT (SIU). The Office of Compliance SIU shall report as appropriate to local and state entities. If you do not receive an acknowledgement of receipt of this form within five (5) working days, please send an email to Fraud@CalOptima.org.

CalOptima Health Board Action Agenda Referral

Action To Be Taken September 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
13. Approve Contract for State and Local Advocacy Services

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

Recommended Action
Authorize the Chief Executive Officer to execute a contract with Strategies 360, Inc. (Strategies 360) for state and local advocacy services, effective October 1, 2023, through October 31, 2026.

Background
CalOptima Health retains representation in Sacramento to assist with tracking and advocacy on legislation, analyzing and developing positions on bills, and analyzing recommended actions pertaining to state budget and regulatory issues. In addition, CalOptima Health representatives develop and maintain relationships with members of the California State Legislature, legislative committee staff and consultants, and state departments and regulatory agencies, including but not limited to the California Department of Health Care Services.

CalOptima Health currently contracts with Edelstein Gilbert Robson & Smith LLC (EGRS) for state advocacy services. Since the CalOptima Health Board of Directors (Board) had exercised all extension options, the contract with EGRS was set to expire on June 30, 2023. To ensure that CalOptima Health has consistent, uninterrupted representation in Sacramento for the remainder of the current legislative session, which is expected to adjourn on September 14, 2023, the Board authorized at its regular meeting on June 1, 2023, a three-month extension of the EGRS contract through September 30, 2023. At the same time, the Board approved the release of a request for proposals (RFP) with an expanded scope of work (SOW) to support increased engagement in Sacramento, as well as locally in Orange County, on issues impacting CalOptima Health and its members, providers, and stakeholders.

Discussion
Consistent with CalOptima Health's procurement process prescribed in policy *GA.5002: Purchasing*, an RFP for state and local advocacy services was issued on June 28, 2023, and publicly advertised in The Capitol Morning Report — the key daily guide to California government and politics read by the State Capitol community. By the submission deadline on July 24, 2023, CalOptima Health received proposals from two advocacy firms: EGRS and Strategies 360. A staff evaluation committee reviewed the submitted written proposals and recommended both firms for interviews. Subsequently, leadership and staff conducted in-person interviews.

The evaluation criteria for the written proposals and interviews included:
- Account team qualifications and experience
- Ability to strengthen CalOptima Health's presence in Sacramento

Back to Agenda

- Ability to advocate at the local level in Orange County
- Ability to bring in subject matter experts (SMEs) as needed for specific legislative matters
- Experience with policy issues impacting CalOptima Health
- Experience with similar client(s)

Following interviews, staff recommended Strategies 360 to provide state and local advocacy services for CalOptima Health. The final weighted scoring was as follows:

Firm	Score
Edelstein Gilbert Robson & Smith LLC	4.0420
Strategies 360, Inc.	4.2431

The scores were close between the two firms. Although the incumbent, EGRS, proposed a lower price consistent with its current contract, the evaluation team recommended selecting Strategies 360 because of its unique capability to meet the requirements of the expanded SOW, particularly regarding engagement in local advocacy efforts in Orange County. In addition, the Strategies 360 account team has strong relationships with key members of Orange County's legislative delegation and has access to several SMEs to support engagement on specific policy issues with legislative and regulatory staff. As such, staff believes Strategies 360 will provide added value to CalOptima Health's Government Affairs program and advocacy efforts.

Staff recommends Board approval of the proposed contract with Strategies 360 for a three-year and one-month period from October 1, 2023, through October 31, 2026, which will re-align the contract schedule with the state legislative cycle and the governor's signing and vetoing deadlines. The proposed contract also includes one two-year extension option exercisable at CalOptima Health's sole discretion with Board approval. Under its submitted proposal, Strategies 360's proposed contract is priced at $12,500 per month, which includes direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, and materials. Not included are any necessary state and local lobbyist registration and filing fees, in an amount up to $2,000 per year, as well as any travel expenses authorized in advance by CalOptima Health in an amount up to $11,000 per year. The estimated cost for state and local advocacy services is $125,500 for the nine-month period of October 1, 2023, through June 30, 2024.

Consistent with the expanded SOW and increased contract price, Strategies 360 will commit additional staff and labor hours in both Sacramento and Orange County in comparison to CalOptima Health's current contract for state advocacy services. As part of standard practice, staff will monitor the performance of Strategies 360 to ensure that the deliverables and components outlined in the contract and SOW are being achieved. Deliverables include, but are not limited to, written and verbal monthly reports, updates, and discussions with staff. When appropriate, Strategies 360 will provide occasional verbal updates at Board meetings.

Fiscal Impact

The funding for the recommended action was an included item for the Government Affairs budget under the CalOptima Health Fiscal Year 2023–24 Operating Budget approved by the Board on

Back to Agenda

June 1, 2023. Management will include expenses for the Strategies 360 contract for the period of July 1, 2024, through October 31, 2026, in future operating budgets.

Rationale for Recommendation

State and local advocacy efforts continue to be a priority for CalOptima Health given the level of activity on health care issues in Sacramento and Orange County. CalOptima Health anticipates that several important issues will require focus, attention, involvement, and advocacy.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. Proposed Strategies 360 Contract No. 24-10170

/s/ Michael Hunn *08/31/2023*
Authorized Signature **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Edelstein Gilbert Robson & Smith LLC	1127 11th St, Suite 1030	Sacramento	CA	95814
Strategies 360, Inc.	555 Capitol Mall, Suite 180	Sacramento	CA	95815

CONTRACT NO. 24-10170 ("**Contract**")
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA HEALTH ("**CalOptima**")
And
STRATEGIES 360, INC.
("**CONTRACTOR**")

This Contract is made and entered into as of October 01, 2023 ("**Effective Date**"), by and between the Orange County Health Authority, a public agency dba CalOptima Health ("**CalOptima**") and Strategies 360, Inc., hereinafter referred to as "**CONTRACTOR**." CalOptima and CONTRACTOR may be referred to herein collectively as the "**Parties**" or each individually as a "**Party**."

RECITALS

A. CalOptima desires to retain a contractor to provide State Advocacy Services, as described in the Scope of Work in Exhibit A;

B. CONTRACTOR provides such services;

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

D. CONTRACTOR desires to perform these services for CalOptima; and

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

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. "**Contract Documents**" include the following documents in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and addenda; (ii) CalOptima's Request for Proposal 23-086 ("**RFP**"), inclusive of any CalOptima revisions and addenda prior to the Effective Date; and (iii) CONTRACTOR's proposal dated July 21, 2023 ("**Proposal**"). Any new terms and conditions attached to CONTRACTOR's best and final offer, Proposal, invoices, or request for payment shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All Contract Documents are incorporated into this Contract by this reference. Any changes to the Contract or the Contract Documents shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima in accordance with Section 10, of this Contract. In the event of any conflict of provisions among the Contract and/or Contract Documents, the provisions shall prevail in the above-referenced descending order of precedence.

2. Scope of Work.

2.1 CONTRACTOR shall perform the work in accordance with (i) this Contract, including the Scope of Work in Exhibit A, (ii) the Contract Documents, (iii) the applicable standards and requirements of the Centers for Medicare and Medicaid Services ("**CMS**"), the California Department of Health Care Services ("**DHCS**"), and the California Department of Managed Health Care ("**DMHC**"), and (iv) all applicable laws.

3. Insurance.

3.1 At CONTRACTOR's sole expense and prior to undertaking performance of services under this Contract and at all times during performance hereunder, CONTRACTOR shall maintain insurance policies and amounts set forth in Exhibit A, which shall be full-coverage insurance not subject to self-insurance provisions, in accordance with applicable laws and industry standards. CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the Term.

3.2 Within five (5) days of the Effective Date and prior to commencing performance of any services or its receipt of any compensation under the Contract, CONTRACTOR shall furnish to CalOptima with additional insured endorsements broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR. CONTRACTOR's Certificates of Insurance shall additionally comply with the following:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR, including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies, as applicable, and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this Contract, the CONTRACTOR's insurance coverage shall be primary insurance with respect to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies, as applicable.

3.2.3 CONTRACTOR's insurance carrier agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the CONTRACTOR for CalOptima. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this Section 3.2 and Exhibit A. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If CONTRACTOR maintains higher limits than the minimums required in this Contract, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

3.2.9 Require the insurance carrier to provide thirty (30) days' prior written notice of cancellation to CalOptima.

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3 and Exhibit A, CalOptima may terminate this Contract upon written notice to CONTRACTOR. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

3.4 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth in this Contract.

3.6 "**Occurrence**" means any event or related exposure to conditions that result in bodily injury or property damage.

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR shall defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "**Indemnified Parties**") against any and all claims, losses, demands, damages, costs, expenses, or liability arising out CONTRACTOR's, or its officers, employees, subcontractors, agents, or representatives', breach of this Contract, negligence, recklessness, or intentional conduct, except to the extent any such loss was caused by the gross negligence, recklessness, or intentional misconduct of CalOptima. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions at its sole expense, which shall include all costs and fees, including attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding. CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except claims arising through the sole negligence or sole willful misconduct of CalOptima.

4.2 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder

4.3 CONTRACTOR's indemnification and duty to defend obligations shall survive the expiration or earlier termination of this Contract until such time as any action against the Indemnified Parties for such a matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including those set forth under the California Government Claims Act (Cal. Gov. Code §900 *et seq*.).

4.4 In the event of any conflict between this Section 4 and the indemnification provisions set forth elsewhere in the Contract, including any business associate agreement ("**BAA**") between the Parties, the indemnification provision(s) in the BAA or elsewhere in the Contract shall be interpreted to relate only to matters within the scope of the BAA or those other Contract provisions.

4.5 The terms of this Section 4 shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which shall include for purposes of this Section 5 all subcontractors, agents, and employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor and nothing in this Contract shall be construed as creating a partnership, joint venture, or agency. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees, agents, and/or subcontractors in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, state and federal income tax withholding, other payroll taxes, unemployment compensation, workers' compensation, and similar matters. CONTRACTOR shall file all required returns related to such taxes, contributions, and payroll deductions.

6. Personnel.

6.1 CONTRACTOR Staffing. CONTRACTOR shall ensure that only fully qualified CONTRACTOR personnel are assigned to perform the services under the Contract, and such CONTRACTOR personnel shall perform services diligently and in a timely manner, according to the applicable professional and technical standards.

6.2 CONTRACTOR Personnel Restrictions. When on CalOptima's premises, CONTRACTOR personnel shall comply with CalOptima policies and procedures, including CalOptima's identification requirements (e.g., name badges).

6.3 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair or replacement by CONTRACTOR at no cost to CalOptima.

6.4 Neither Party shall actively solicit employees of the other Party for employment that directly or indirectly provided services under the Contract during the Term and for a period of one (1) year after termination.

7. Compensation.

7.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full compensation for the faithful performance of this Contract, the rates, charges, and other payment terms identified in Exhibit B.

7.2 CalOptima will not reimburse CONTRACTOR any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

7.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance set forth in the Contract and Exhibit A. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES, OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN**

RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING BY CALOPTIMA UNDER THIS CONTRACT.

7.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in Exhibit B, without the express prior written authorization of CalOptima. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

7.5 The maximum cumulative payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. CONTRACTOR is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise to be paid by CalOptima to CONTRACTOR due to CONTRACTOR'S failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed and pay them to the appropriate taxing authority and shall have no liability for or any obligation to refund any payments withheld.

8. Confidential Material.

8.1 During the Term, either Party may have access to confidential material or information ("**Confidential Information**") belonging to the other Party or the other Party's customers, vendors, or partners. Confidential Information includes the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements, projections, methodologies, data, reports, agreements, intellectual property, trade secrets, licensing plans, and other proprietary information, or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. CalOptima's Confidential Information also includes all user information, patient information, and clinical data that comes into CalOptima's possession, custody or control. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

8.2 For the purposes of Section 8.1, Confidential Information does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other Party's Confidential Information or proprietary information; (iv) is lawfully received from a third party that is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure, pursuant to California Public Records Act, Government Code Section 6250 *et seq*., applicable provisions of California Welfare and Institutions Code, or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

8.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers, or agents, who are bound by confidentiality obligations no less stringent than those in this Section 8, on a "need to know" basis in connection with the services performed under this Contract. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; provided, however, that the receiving Party gives reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and assists the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or court does not relieve the receiving Party of its confidentiality obligations with respect to the other Party.

8.4 CONTRACTOR shall establish and maintain environmental, safety, and facility procedures, data security procedures and other safeguards against the unauthorized access, destruction, loss, or alteration of CalOptima's Confidential Information in the possession, custody, or control of CONTRACTOR. Those security procedures and other safeguards shall be no less rigorous than those maintained by CONTRACTOR for its own information of a similar nature.

8.5 Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party or destroy all documents, notes, and other tangible materials representing the disclosing Party's Confidential Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

8.6 If a breach of the obligations under this Section 8 occurs, the injured Party may be entitled to such injunctive relief and any and all other remedies available at law or in equity. This Section 8 in no way limits the liability or damages that may be assessed against a Party if another Party breaches any of the provisions of this Section 8.

8.7 This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit protected health information ("**PHI**"). As such, no BAA is required for this Contract; provided, however, that if CONTRACTOR or its employees, agents, or subcontractors access or receive, whether intentionally or unintentionally, PHI regarding CalOptima members during the Term, CONRACTOR and its employees, agents, and subcontractors shall immediately notify CalOptima, protect such PHI from any additional disclosure, not use or disclose that PHI in any way that would violate a federal or state privacy or security law, its implementing regulations, or any other state or federal law, and execute a BAA with CalOptima, as necessary and requested by CalOptima.

9. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 *et seq*.) (the "**PRA**"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless exempt from disclosure under the provisions of the PRA. CalOptima may be required to reveal certain information pursuant to the PRA believed to be proprietary or confidential by CONTRACTOR. If CONTRACTOR discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the PRA that are not so marked. If CalOptima receives a request under the PRA that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. Within five (5) days from receipt of CalOptima's notice, CONTRACTOR shall notify CalOptima if it intends to object to production of CONTRACTOR's information; otherwise CalOptima will respond to the PRA request according to the requirements of the PRA. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including attorneys' fees, and any costs awarded to the person or entity that sought CONTRACTOR's marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR-marked material (collectively referred to for purposes of this Section 9 as "**Public Records Act Claim(s)**"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

10. Modifications. CalOptima may modify the Contract upon written notice to CONTRACTOR at any time should such modification be required by CMS, DHCS, the DMHC, or applicable law or regulation ("**Regulatory Amendment**"). Any other modifications of the Contract that are not Regulatory

Amendments shall be executed only by a written amendment to the Contract, signed by CalOptima and CONTRACTOR. Execution of amendments shall be contingent upon CONTRACTOR's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for CONTRACTOR's performance.

11. Assignments.

11.1 CONTRACTOR may not assign, transfer, or delegate any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole discretion. If CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, or delegation may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, or delegation made without CalOptima's express written consent shall be void.

11.2 For purposes of this Section 11, an assignment is: (1) the change of more than fifty percent (50%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than fifty percent (50%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

12. Subcontracts. CONTRACTOR may not subcontract or delegate its obligations or the performance of services under this Contract without CalOptima's prior written consent, which CalOptima may exercise in its sole discretion. CalOptima-approved subcontractors are listed in Addendum 1 to Exhibit A.

13. Term. This Contract shall commence on the Effective Date and shall continue in full force and effect through 10/31/2026 ("**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 two (2)-year term ("**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. The Initial Term together with any Extended Terms constitute the "**Term**" of this Contract.

14. Termination.

14.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days' prior written notice. Upon termination, CalOptima shall pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

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

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

14.2.2 In the event of termination under Section 14.2.1, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall

not be entitled to payment for any other items, including lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

14.3 Termination for Default. CalOptima may immediately terminate this Contract upon notice to CONTRACTOR for (i) CONTRACTOR's default, (ii) if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR; or (iii) if CONTRACTOR makes an assignment, as defined in Section 11, for the benefit of creditors ("**Termination for Default**").

14.4 Termination for Breach. Either Party may at its option, terminate this Contract by notice to the other Party if the other Party breaches one of its obligations under this Contract and fails to cure that breach or default within thirty (30) days after receiving notice identifying that breach, provided that the non-breaching party may terminate the Contract immediately upon written notice if the non-breaching Party reasonably determines that cure of the default within thirty (30) days is impossible. The rights described in this Section 14.4 to terminate this Contract shall be in addition to any other remedy available to the non-breaching Party, whether under this Contract or in law or equity, on account of that breach.

14.5 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3 (Insurance) or Section 8 (Confidential Material).

14.6 Effect of Termination. Upon expiration or receipt of a termination notice under this Section 14:

14.6.1 CONTRACTOR shall promptly discontinue all services (unless CalOptima's notice directs otherwise) and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs, and any other products, data and such other materials, equipment, and information, including Confidential Information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure.

14.6.2 CalOptima may take over the services and may award another party a contract to complete the services under this Contract.

14.6.3 In the event of termination under Sections 14..3, 14.4, or 14.5, either Party shall be liable for any and all reasonable costs incurred by the non-breaching Party as a result of such a termination.

15. Dispute Resolution

15.1 Meet and Confer. If either Party has a dispute arising under or related to this Contract, the Parties shall informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 15.2.

15.2 Subject to the California Government Claims Act (Cal. Gov. Code §900 *et seq*.) governing claims against public entities, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS;

provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

15.3 Exclusive Remedy. With the exception of any dispute that under applicable laws may not be settled through arbitration, arbitration under Section 15.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the meet-and-confer processes.

15.4 Waiver. By agreeing to binding arbitration as set forth in Section 15.2, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

16. General Provisions.

16.1 Non-Exclusive Relationship. This is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

16.2 Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima vendor policies relating to services under the Contract that are in effect when this Contract is signed or that come into effect during the Term and are available to CONTRACTOR on CalOptima's website.

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

16.4 Time is of the Essence. Time is of the essence in performance of this Contract.

16.5 Choice of Law. This Contract shall be governed by and construed in accordance with all laws of the State of California. If any Party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in the County of Orange, California.

16.6 Force Majeure. When satisfactory evidence of a cause beyond a Party's control is presented to the other Party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the Party not performing, a Party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause,

including any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local governments, or a material act or omission by the other Party. A Party invoking this clause shall provide the other Party with prompt written notice of any delay or failure to perform that occurs by reason of force majeure. If the force majeure event continues for a period of Ten (10) days, the Party unaffected by the force majeure event may terminate this Contract upon notice to the other Party.

16.7 Notices. All notices required or permitted under this Contract shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any notice not related to termination of this Contract may be submitted electronically to the address set forth below. Any Party whose address changes shall notify the other Party in writing.

To CONTRACTOR:	**To CalOptima Health:**
Strategies 360, Inc.	CalOptima Health
555 Capitol Mall Suite 180	505 City Parkway West
Sacramento, CA 95815	Orange, CA 92868
Attention: Debbie Daly	Attention: Kim Marquez
Email: DebbieD@Strategies360.com	Email: kmarquez2@caloptima.org

16.8 Notice of Labor Disputes. Whenever CONTRACTOR has knowledge that any actual or potential labor dispute may delay this Contract, CONTRACTOR shall immediately notify and submit all relevant information to CalOptima.

16.9 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the Parties agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability related to this Contract. [County of Orange Ordinance No 3896, codified in Orange County Municipal Code Section 4-11-7(a)]

16.10 Entire Agreement. This Contract, including all exhibits, addenda, and Contract Documents, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations, and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

16.11 Waiver. Any failure of a Party to insist upon strict compliance with any provision of this Contract shall not be deemed a waiver of such provision or any other provision of this Contract. To be effective, a waiver must be in a writing that is signed and dated by the Parties. A waiver by either of the Parties of a breach of any of the covenants, conditions, or agreements to be performed by the other Party shall not be construed to be a waiver of any succeeding breach of the Contract or of any other covenant or condition of the Contract. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged, or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

16.12 Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Sections 4 (Indemnification), 5 (Independent Contractor), 8 (Confidential Material), 9 (California Public Records Act), 14.6 (Effect of Termination), 15 (Dispute Resolution), 16.3 (Names and Marks), 16.5 (Choice of Law), 16.9 (No Liability of County of Orange), this Section 16.12, 16.14 (Interpretation), 16.15 (Third-Party Beneficiaries), 16.16 (Successors and Assigns) and any other Contract provisions that by their nature are intended to survive termination or expiration of this Contract.

16.13 Severability. If any section, subsection or provision of this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall remain in effect.

16.14 Interpretation. The terms of this Contract are the result of negotiation between the Parties. Accordingly, any rule of construction of contracts (including California Civil Code Section 1654) that ambiguities are to be construed against the drafting party shall not be employed in the interpretation of this Contract.

16.15 Third Party Beneficiaries. There are no intended third-party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

16.16 Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties. Nothing in this Contract is intended to confer upon any party other than the Parties or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

16.17 Without Limitation. Any reference in the Contract to "include(s)" or "including" means inclusion without limitation, unless otherwise distinguished within the text.

16.18 Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

16.19 Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

16.20 Recitals and Exhibits. The recitals, exhibits, and addenda attached to this Contract are made a part of the Contract by this reference.

[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. 24-10170 on the day and year last shown below.

Strategies 360, Inc.	CalOptima Health
By: 	By:
Print Name: Ron Dotzauer	Print Name:
Title: CEO Date: 08/28/2023	Title: Date:

By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

EXHIBIT A
Scope of Work

1. **Description of Work**

Purpose

CONTRACTOR shall represent CalOptima's interests, as specified below, in Sacramento and have the responsibility of monitoring and influencing legislative and regulatory policies, building and maintaining positive and mutually beneficial relationships with officials, and providing CalOptima with necessary advocacy services.

Reporting Relationship

The Chief Executive Officer; Chief Operating Officer; Chief of Staff; Senior Director, State Government Affairs; and Senior Manager, Government Affairs; and/or their designee(s), will be the primary contacts and will direct the work of the CONTRACTOR.

Objectives/Deliverables

CONTRACTOR agrees to provide to CalOptima, as requested by CalOptima, the following services:

1. Register and serve as a legislative advocate for CalOptima pursuant to the rules and procedures of the Fair Political Practices Commission and any other necessary entities for which registration may be necessary.

2. Regularly consult with CalOptima's primary contacts and other contracted advocacy firms regarding CalOptima's government affairs program.

3. Develop a robust, proactive advocacy strategy with CalOptima's Government Affairs Department, Executive Office, and Board, including by providing ongoing legislative/political analysis and strategic and tactical recommendations regarding CalOptima's advocacy priorities and activities.

4. Maintain regular contact with leadership and staff of the government of the State of California, including but not limited to the following entities:
    - California State Legislature;
    - Governor's Office;
    - California Health and Human Services Agency (CalHHS);
    - Department of Health Care Services (DHCS);
    - Department of Managed Health Care (DMHC);
    - Department of Health Care Access and Innovation (HCAI); and
    - Any other state departments, agencies, boards, city councils and other local elected officials, and commissions, when directed by CalOptima.

5. Prioritize the development of relationships with state legislators who represent any portion of Orange County, as well as any staff thereof, to improve their awareness and positive perception of CalOptima, secure their alignment with and advocacy for CalOptima's positions, and improve opportunities for current and future collaboration.

6. As directed by CalOptima, brief Orange County's legislative delegation with CalOptima updates, publications and other informational items. These may include the annual Report to the Community, Fast Facts, and other materials.

7. Arrange meetings and briefings for CalOptima Board and staff with state officials and staff. CONTRACTOR shall be proactive in scheduling strategic, targeted meetings and briefings, especially but not limited to times when CalOptima Board and staff are scheduled to be in Sacramento. Meetings and briefings may include formal briefings, as well as informal social meetings, as appropriate.

8. Notify CalOptima of anticipated, introduced or amended state legislation, as well as proposed and final administrative, budgetary, and regulatory actions which could impact CalOptima. These activities include but are not limited to the following:
    - Providing the bill number and brief summary of introduced or amended state legislation;

- Providing copies of legislation, committee analysis, and any other relevant analyses;
- Providing information relative to legislative hearings;
- Providing a brief summary of proposed and final administrative, budgetary, and regulatory actions; and
- Providing recommendations regarding CalOptima's response, engagement, and advocacy.

9. Identify new program and funding opportunities that relate to CalOptima.

10. Advocate for CalOptima's programs, positions on legislation introduced in the California State Legislature, and administrative, budgetary, and regulatory proposals introduced by state agencies and the Governor's Office. Advocacy activities include but are not limited to the following:
    - Developing and implementing an advocacy strategy;
    - Coordinating and engaging in virtual and in-person meetings;
    - Drafting and submitting written letters of support and opposition;
    - Drafting bill amendments to proposed legislation, as well as circulating and securing support for such amendments from legislators and their staff;
    - Identifying witnesses, preparing written testimony, and delivering verbal testimony as directed before committees of the Legislature; and
    - Creating and leading necessary advocacy coalitions.

11. Proactively identify and engage in additional opportunities for CalOptima to influence state legislative, regulatory, budgetary, and administrative proposals and policymaking processes for the benefit of CalOptima.

12. Maintain relationships with, and engage in partnership opportunities with, trade associations and other health care and non-health care organizations to advance CalOptima's shared advocacy priorities.

13. Provide monthly, written reports which shall include a state budget and legislative update, as well as a description of the nature and extent of services or actions taken on behalf of CalOptima. The services and actions shall include a summary of the CONTRACTOR's meetings along with the issues discussed with members of the California State Legislature, legislative staff, and relevant committee staff, as well as appropriate state departments, agencies, boards, commissions, committees, and staff. The reports shall be delivered on a schedule as directed by CalOptima staff and may be included in the CalOptima Board book and/or provided to Board members. The frequency of written reports may be modified at any time.

14. Provide in-person or over-the-phone briefings, as directed by CalOptima staff, to the CalOptima Board and executive staff.

15. Provide copies of all written correspondence, testimony, and position papers given on behalf of CalOptima, as well as access to the state budget and any related documents (including but not limited to DHCS and Legislative Analyst's Office analyses) as they become available.

16. As-needed State & Local Orange County Government Lobbyist Registrations which includes preparing and submitting quarterly State Lobbying Disclosures.

CalOptima staff may prepare a formal annual review of CONTRACTOR's work product at the end of each calendar/fiscal year.

Performance of Duties
CONTRACTOR agents shall faithfully, industriously, and to the best of their ability, experience, and talents, perform all of the duties that may reasonably be assigned to him or her hereunder and devote such time to the performance of such duties as may be necessary, therefore.

2. **Standard of Performance; Warranties**.

2.1 CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

2.2 If CONTRACTOR may subcontract for services under this Contract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work and will comply with all applicable provisions of this Contract.

2.3 CONTRACTOR expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. CONTRACTOR further warrants that all material covered by this Contract, if any, which is the product of CONTRACTOR will be new and unused unless otherwise specified and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to CONTRACTOR. CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage resulting from such defects. CalOptima shall give notice to CONTRACTOR of any observed defects. If CONTRACTOR fails to adjust, repair, correct, or perform other work made necessary by such defects, CalOptima may make such adjustments, repairs, and/or corrections and charge CONTRACTOR the costs incurred.

2.4 CONTRACTOR's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

2.5 CONTRACTOR's obligations under this Section 2 are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both Parties.

2.6 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair or replacement by CONTRACTOR at no cost to CalOptima.

3. **Record Ownership and Retention**.

3.1 The originals of all letters, documents, reports, and any other products and data prepared or generated for the purposes of this Contract shall be delivered to and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

3.2 CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("**Works**"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including documents relating to patent, trademark and copyright applications. Upon CalOptima's request,

CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

4. **Required Insurance**

4.1. Commercial General Liability, including contractual liability and coverage for independent contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

4.1.1. Per occurrence: $1,000,000

4.1.2. Personal Advertising Injury: $1,000,000

4.1.3. Products Completed Operations: $2,000,000

4.1.4. General Aggregate: $2,000,000

4.2. If Contractor or subcontractors are on CalOptima's premises or transporting CalOptima members or employees, Commercial Automobile Liability covering any auto, whether owned, lease, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

4.3. Worker's Compensation and Employer's Liability Policy written in accordance with applicable laws and providing coverage for all of CONTRACTOR's employees:

4.3.1. The policy must provide statutory coverage for Worker's Compensation.

4.3.2. The policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

4.4. Professional Liability insurance covering the CONTRACTOR's professional errors and omissions with $1,000,000 per occurrence and $2,000,000 general aggregate.

4.5. Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and them of client property with $1,000,000 limits per occurrence.

4.6. Cyber and Privacy Liability insurance with the minimum limits of insurance listed below 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 CalOptima and for claims involving any professional services for which CONTRACTOR is engaged with CalOptima for such length of time as necessary to cover any and all claims.

4.6.1. Privacy and Network Liability: $1,000,000
4.6.2. Internet Media Liability: $1,000,000
4.6.3. Business Interruption & Expense: $1,000,000
4.6.4. Data Extortion: $1,000,000
4.6.5. Regulatory Proceeding: $1,000,000
4.6.6. Data Breach Notification & Credit Monitoring: $1,000,000

EXHIBIT A
Addendum 1

The following is a list of subcontractors approved to perform Services under this Contract:

Subcontractor Name	Functions

EXHIBIT B
Payment

1. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR for fees and expenses in accordance with the provisions of this Exhibit B and subject to the maximum cumulative payment obligations specified below.

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

3. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 24-10170; specify the number of hours worked; the specific dates the hours were worked; the description of work performed; the time period covered by the invoice and the amount of payment requested; and be accompanied by a progress report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

4. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that CalOptima's maximum cumulative payment obligation hereunder for work performed in Exhibit A of this Contract shall not exceed One Hundred Fifty Thousand Dollars ($150,000.00), including all amounts payable to CONTRACTOR for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract.

5. CONTRACTOR's monthly fixed billable rate shall be Twelve Thousand Five Hundred Dollars ($12,500.00) for work performed in Exhibit A of this Contract. This rate is fixed for the duration of the Contract. CalOptima shall not pay CONTRACTOR for time spent traveling.

6. Not included in the maximum cumulative payment obligation above, CONTRACTOR shall pass-through the fees to CalOptima monthly, as applicable, for the State & Local Orange County Government Lobbyist Registrations, which include the quarterly state lobbyist disclosures. These fees are estimated to be under Two Thousand Dollars ($2,000.00) per year.

7. Not included in the maximum cumulative payment obligation above, If CONTRACTOR incurs travel-related expenses under this Contract, CalOptima will only reimburse such expenses if CalOptima provides prior written approval of such expenses and those expenses are incurred and submitted in accordance with CalOptima Travel Policy (G.A.5004), as amended, which is incorporated into this Contract by this reference. CalOptima will make CalOptima Travel Policy (G.A.5004) available to CONTRACTOR upon written request. Annual maximum cumulative payment obligation for travel shall not exceed Eleven Thousand Dollars ($11,000.00).

EXHIBIT B-1

[Not applicable to this Contract]

EXHIBIT C
Regulatory Requirements

CalOptima is a public agency and is licensed by the DMHC. In addition, CalOptima arranges for the provision of Medi-Cal services to Medi-Cal beneficiaries under a contract with DHCS ("**DHCS Contract**") and Medicare Advantage ("**MA**") services to Medicare beneficiaries under a contract CMS ("**CMS Contract**"). This Exhibit C sets forth the statutory, regulatory, and contractual requirements that CalOptima must incorporate into the Contract as a public agency and DMHC-licensed health care service plan with MA and Medi-Cal products.

1. **Medi-Cal Requirements**.

1.1. Compliance with Medi-Cal Standards. CONTRACTOR agrees that the Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract. CONTRACTOR shall comply with all applicable requirements of the Medi-Cal program and comply with all monitoring of the DHCS Contract and any other monitoring requests by DHCS.

1.2. Disclosure of Officers, Owners, Stockholders and Creditors. Pursuant to Exhibit E, Attachment 2, Section 33 (a) of the DHCS Contract and 42 C.F.R. Section 455.104, upon the Effective Date, on an annual basis, and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit D of this Contract and submitting the form to CalOptima:

1.2.1. All officers and owners who own greater than five percent (5%) of the CONTRACTOR;

1.2.2. All stockholders owning greater than five percent (5%) of any stock issued by CONTRACTOR; and

1.2.3. All creditors of CONTRACTOR's business if such interest is over five percent (5%).

1.3. Compliance with Employment and Labor Laws. Each Party shall, at its own expense, comply with all applicable laws in performing their respective obligations under the Contract, including, but not limited to, the National Labor Relations Act, the Americans With Disabilities Act, all applicable employment discrimination laws, overtime laws, tax laws, immigration laws, workers' compensation laws, occupational safety and health laws, and unemployment insurance laws and any regulations related thereto. CONTRACTOR acknowledges and agrees that:

1.3.1. CONTRACTOR and its subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. CONTRACTOR and its subcontractors will take affirmative action to ensure that qualified applicants are employed and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. CONTRACTOR and its subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices provided by the federal government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state CONTRACTOR and its subcontractors' obligation to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees. [DHCS Contract, Exhibit D(F), Provision 1, Section A]

1.3.2. CONTRACTOR and its subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its subcontractors, state that all qualified applicants

will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. [DHCS Contract, Exhibit D(F), Provision 1, Section B]

1.3.3. CONTRACTOR and its subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State of California, advising the labor union or workers' representative of CONTRACTOR and its subcontractors' commitments under this Section 1.3 and shall post copies of the notice in conspicuous places available to employees and applicants for employment. [DHCS Contract, Exhibit D(F), Provision 1, Section C]

1.3.4. CONTRACTOR and its subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212), and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", and of the rules, regulations, and relevant orders of the Secretary of Labor. [DHCS Contract, Exhibit D(F), Provision 1, Section D]

1.3.5. CONTRACTOR and its subcontractors will furnish all information and reports required by Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246, Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders. [DHCS Contract, Exhibit D(F), Provision 1, Section E]

1.3.6. If CONTRACTOR and its subcontractors' do not comply with the requirements of this Section 1.3 or with any federal rules, regulations, or orders referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246, as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law. [DHCS Contract, Exhibit D(F), Provision 1, Section F]

1.3.7. CONTRACTOR and its subcontractors will include the provisions of this Section 1.3 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor. CONTRACTOR and its subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that if CONTRACTOR and its subcontractors become involved in, or are threatened with litigation by a subcontractor as a result of such direction by DHCS, CONTRACTOR and its subcontractors may request in writing to DHCS, which, in turn, may request the United States to enter into such litigation

to protect the interests of the State of California and of the United States. [DHCS Contract, Exhibit D(F), Provision 1.G]

1.4. Debarment and Suspension Certification.

1.4.1. By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable federal suspension and debarment regulations, including, as applicable, 7 C.F.R. 3017, 45 C.F.R. 76, 40 C.F.R. 32, or 34 C.F.R. 85. [DHCS Contract, Exhibit D(F), Provision 19, Section A]

1.4.2. By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

1.4.2.1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any state or federal department or agency; [DHCS Contract, Exhibit D(F), Provision 19, Section B.1]

1.4.2.2. Have not within a three (3)-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction; violation of federal or state anti-trust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; [DHCS Contract, Exhibit D(F), Provision 19, Section B.2]

1.4.2.3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the offenses enumerated in Section 1.4.2.2 of this Exhibit C; [DHCS Contract, Exhibit D(F), Provision 19, Section B.3]

1.4.2.4. Have not within a three (3)-year period preceding the Effective Date of this Contract had one or more public transactions (federal, state or local) terminated for cause or default; [DHCS Contract, Exhibit D(F), Provision 19, Section B.4]

1.4.2.5. Have not and shall not knowingly enter into any lower-tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 C.F.R. 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State of California; and [DHCS Contract, Exhibit D(F), Provision 19, Section B.5]

1.4.2.6. Will include a clause entitled, "Debarment and Suspension Certification" that sets forth the provisions herein in all lower-tier covered transactions and in all solicitations for lower-tier covered transactions. [DHCS Contract, Exhibit D(F), Provision 19, Section B.6]

1.4.3. If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima. [DHCS Contract, Exhibit D(F), Provision 19, Section C]

1.4.4. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549. [DHCS Contract, Exhibit D(F), Provision 19, Section D]

1.4.5. If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause or default. [DHCS Contract, Exhibit D(F), Provision 19, Section E]

1.5. Lobbying Restrictions and Disclosure Certification.

1.5.1. *Certification and Disclosure Requirements*.

1.5.1.1. If Contract is subject to 31 U.S.C. § 1352 and exceeds $100,000 at any tier, CONTRACTOR and its subcontractors, as applicable, shall file a certification (in the form set forth in Exhibit E, consisting of one page, entitled "Certification Regarding Lobbying") that CONTRACTOR and its subcontractors, as applicable, have not made, and will not make, any payment prohibited by Section 1.5.2 below. [DHCS Contract, Exhibit D(F), Provision 31, Section A.1; 31 U.S.C. § 1352]

1.5.1.2. CONTRACTOR and its subcontractors, as applicable, shall file a disclosure (in the form set forth in Exhibit E, entitled "Certification Regarding Lobbying") if CONTRACTOR and its subcontractors, as applicable, have made or agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with the Contract or a subcontract thereunder that would be prohibited under Section 1.5.2 below if paid for with appropriated funds. [DHCS Contract, Exhibit D(F), Provision 31, Section A.2]

1.5.1.3. CONTRACTOR and its subcontractors, as applicable, shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by CONTRACTOR and its subcontractors, as applicable, under this Section 1.5.1. An event that materially affects the accuracy of the information reported includes: [DHCS Contract, Exhibit D(F), Provision 31, Section A.3]

1.5.1.3.1. A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action; [DHCS Contract, Exhibit D(F), Provision 31, Section A.3.a]

1.5.1.3.2. A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or [DHCS Contract, Exhibit D(F), Provision 31, Section A.3.b]

1.5.1.3.3. A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action. [DHCS Contract, Exhibit D(F), Provision 31, Section A.3.c]

1.5.1.3.4. As applicable and required by this Section 1.5, CONTRACTOR's subcontractors shall file a certification and a disclosure form, if required, to the next tier above. [DHCS Contract, Exhibit D(F), Provision 31, Section A.4]

1.5.1.3.5. All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by CONTRACTOR. CONTRACTOR shall forward all disclosure forms to CalOptima. [DHCS Contract, Exhibit D(F), Provision 31, Section A.5]

1.5.2. *Prohibition*. 31 U.S.C. § 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. [DHCS Contract, Exhibit D(F), Provision 31, Section B]

1.6. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of CalOptima, the Secretary of Health and Human Services Office of Inspector General, the Comptroller General of the United States, the U.S. Department of Justice, DHCS, the DMHC, the Bureau of Medical Fraud, or any of their duly authorized representatives copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement with a CONTRACTOR subcontractor or an organization related to a CONTRACTOR subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors. [DHCS Contract, Exhibit E, Attachment 2, Provision 20]

1.7. Confidentiality of Member Information.

1.7.1. If CONTRACTOR and its employees, agents, or subcontractors access or receive, whether intentionally or unintentionally, personally identifying information during the Term, CONTRACTOR and its employees, agents, and subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out the express terms of and CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information, except requests for medical records in accordance with applicable law, not emanating from the CalOptima member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the CalOptima member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima specifying that the information is releasable under Title 42 C.F.R. Section 431.300 *et seq*., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under. For purposes of this Section 1.7, identity shall include name, identifying number, symbol, or other identifying detail assigned to the individual, such as finger or voice print or a photograph. [DHCS Contract, Exhibit D(F), Provision 12, Exhibit E, Attachment 2, Provision 22, Section B]

1.7.2. Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 C.F.R. Section 431.300 *et seq*., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to CalOptima members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a CalOptima member under this Contract that is obtained by CONTRACTOR or its subcontractors, CONTRACTOR will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose. [DHCS Contract, Exhibit E, Attachment 2, Provision 22]

1.8. Member Hold Harmless. To the extent CONTRACTOR provides services or supplies to CalOptima members, CONTRACTOR hereby agrees that in no event, including nonpayment by CalOptima, the insolvency of CalOptima, or breach of the Contract, shall CONTRACTOR bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against CalOptima members, persons acting on their behalf, or DHCS. CONTRACTOR further agrees that this hold harmless provision shall survive the termination of the Contract regardless of the cause giving rise to the termination, shall be construed to be for the benefit of CalOptima members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between CalOptima or CONTRACTOR and a CalOptima member or persons acting on their behalf that relates to liability for payment for services under the Contract. [DHCS Contract, Exhibit A, Attachment 6, Provision 13, Section B.15; CMS Medicare Managed Care Manual Chapter 11, Section 100.4]

1.9. Member Grievances. CONTRACTOR shall cooperate with CalOptima's member grievances and appeals procedures as necessary for CalOptima to carry out its legal obligations. [DHCS Contract, Exhibit A, Attachment 14; 28 C.C.R. §§ 1300.68, 1300.68.01; 22 CCR § 53858; 43 C.F.R. § 438.402-424]

1.10. Air and Water Pollution Requirements. If this Contract or any subcontract thereunder is in excess of one hundred thousand dollars ($100,000), CONTRACTOR agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 *et seq*.), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 *et seq*.), as amended. [DHCS Contract, Exhibit D(F), Provision 11]

2. **Medicare Requirements**.

2.1. CONTRACTOR expressly warrants that CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with all applicable Medicare laws, regulations, and CMS instructions. CONTRACTOR further agrees and acknowledges that this provision will be included in all agreements with CONTRACTOR's subcontractors.

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

2.2.1. Abide by all federal and state laws regarding confidentiality and disclosure of medical records and other health and enrollment information. CONTRACTOR shall safeguard the privacy of any information that identifies a particular enrollee and shall have procedures that specify: (a) the purposes for which the information will be used within CONTRACTOR's organization; and (b) to whom and for what purposes CONTRACTOR will disclose the information.

2.2.2. Ensure that the medical information is used and released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas.

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

2.3. CONTRACTOR shall comply with the reporting requirements provided in 42 C.F.R. § 422.516, as well as the encounter data submission requirements in 42 C.F.R. § 422.257.

2.4. For all contracts in the amount of $100,000 or more, CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with 41 C.F.R. 60-300.5(a) and 41 C.F.R. 60-741.5(a) as follows:

2.4.1. CONTRACTOR and its subcontractors shall abide by the requirements of 41 C.F.R. § 60-300.5(a). This regulation prohibits discrimination against qualified protected veterans and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified protected veterans. [41 C.F.R. § 60-300.5(d)]

2.4.2. CONTRACTOR and its subcontractors shall abide by the requirements of 41 C.F.R. § 60-741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities. [41 C.F.R. § 60-741.5(d)]

2.5. In addition to the termination provisions of Section 14 of the Contract, CalOptima may terminate the Contract if CMS or CalOptima determines that CONTRACTOR has not satisfactorily performed its obligations under the Contract. Under such circumstances, CalOptima may pay CONTRACTOR its allowable costs incurred to the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima for matters pertaining to this Contract.

2.6. While CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of the CMS Contract, CONTRACTOR shall comply with all such applicable requirements in the CMS Contract, at the direction of CalOptima.

2.7. CONTRACTOR shall ensure that the persons it employs or contracts with for the provision of services pursuant to the Contract are in good standing and not on the preclusion list, defined in 42 C.F.R. § 422.2. CONTRACTOR shall promptly disclose to CalOptima any exclusion or other event that makes a CONTRACTOR employee or subcontractor ineligible to perform work related to federal health care programs. CONTRACTOR agrees to be bound by the provisions set forth at 2 C.F.R. Part 376. [42 C.F.R. § 422.752(a)(8)]

3. **Offshore Performance**.

3.1. Due to security and identity protection concerns, direct services under this Contract shall not be performed by offshore subcontractors, unless otherwise authorized in writing by CalOptima prior to the provision of those services.

3.2. CONTRACTOR shall complete, sign, and return Exhibit G, "Attestation Concerning the Use of Offshore Subcontractors" as of the Effective Date and shall submit an executed Offshore Subcontractor Attestation to CalOptima no less than annually thereafter. CONTRACTOR represents and warrants that it has disclosed in Exhibit G any and all such offshore subcontractors and that it has obtained CalOptima's written approval to use such offshore subcontractors prior to the Effective Date.

3.3. Any subcontract with an offshore entity under which the offshore entity will have access to any confidential CalOptima member or other protected health information must be approved in writing by CalOptima prior to execution of the subcontract. CONTRACTOR is required to submit future Offshore Contractor Attestations to CalOptima within thirty (30) calendar days after it has signed a contract with any subcontractor that may be using an offshore subcontractor to perform any related work.

3.4. Unless specifically stated otherwise in this Contract, the restrictions of this Section 3 do not apply to indirect or "overhead" services, or services that are incidental to the performance of the Contract.

3.5. The provisions of this Section 3 apply to work performed by subcontractors at all tiers.

4. **Prohibited Interest**.

4.1. CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict-of-interest laws, including CalOptima's Conflict of Interest Code, the California Political Reform Act (California Government Code § 81000 *et seq*.) and California Government Code § 1090 *et seq*. (collectively, the "**Conflict of Interest Laws**").

4.2. CONTRACTOR covenants that, to the best of its knowledge during the Term, no director, officer, or employee of CalOptima during his or her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the Term, and consistent with the provisions

of 22 C.C.R. § 53600(f), no state officer or state employee shall be employed in a management or contractor position by CONTRACTOR within one (1) year after the state office or state employee has terminated state employment.

4.3. CONTRACTOR, and any person designated by CONTRACTOR to make or participate in making a governmental decision on behalf of CalOptima, is considered a "**Consultant**" pursuant to CalOptima's Conflict of Interest Code and shall be required to file a statement of economic interests (Fair Political Practices Commission Form 700) with CalOptima annually. [2 C.C.R. Section 18734]

4.4. CONTRACTOR understands that if this Contract is made in violation of California Government Code § 1090 *et seq*., the entire Contract is voidable, CONTRACTOR will not be entitled to any compensation for services performed pursuant to this Contract, and CONTRACTOR will be required to reimburse CalOptima any sums paid to CONTRACTOR. CONTRACTOR further understands that CONTRACTOR may be subject to criminal prosecution for a violation of California Government Code § 1090.

4.5. If CONTRACTOR becomes aware of any facts that might reasonably be expected to either create a conflict of interest under the Conflict of Interest Laws or violate the provisions of this Section 4, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include identification of all persons, entities, and businesses implicated and a complete description of all relevant circumstances.

5. **State Auditor Audit Disclosure**. Pursuant to California Government Code § 8546.7, if this Contract is more than ten thousand dollars ($10,000), it is subject to examination and audit of the California State Auditor, at the request of CalOptima or as part of any audit of CalOptima for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract, CONTRACTOR agrees that during the Term and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period. [Gov't Code § 8546.7]

EXHIBIT D
Medi-Cal Disclosure Form

Contractor Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: Strategies 360 Inc.

Business Entity Type: S-Corporation
(*Sole Proprietorship, Partnership, LLC, California Corporation, etc.*)

Business Address: 1505 Westlake Ave N Ste 1000

City: Seattle State: WA Zip: 98109

Business Phone: 206.282.1990 Email: : finance@strategies360.com

President: Karen Waters Contact Person: Danielle Sires

Person(s) Signing Contract & Title: : Ron Dotzauer, CEO

*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 %
RonDotzauer	CEO

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

Authorized Signature — August 28, 2023 (Date)

Ron Dotzuaer, CEO
Name and Title

EXHIBIT E

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this federal contract, federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this federal contract, grant, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities"' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Strategies 360 Inc	Ron Dotzauer
Name of Contractor	Printed Name of Person Signing for Contractor
24-10170	
Contract/Grant Number	Signature of Person Signing for Contractor
August 28, 2023	CEO
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
☐a. contract ☐b. grant ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	☐a. bid/offer/application ☐b. initial award ☐c. post-award	☐a. initial filing ☐b. material change **For Material Change Only:** Year _____ quarter_____ date of last report _____

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
☐ Prime ☐ Subawardee Tier ____, *if known*: Congressional District, *if known*:	Congressional District, *if known*:
6. Federal Department/Agency:	7. Federal Program Name/Description: CDFA Number, *if applicable*:
8. Federal Action Number, *if known*:	9. Award Amount, *if known*: $_____
10. a. Name and Address of Lobbying Entity (*If individual, last name, first name, MI*):	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):
(*attach Continuation Sheet(s) SF-LLLA, if necessary*)	
11. Amount of Payment (check all that apply): $_____ ☐actual ☐planned	13. Type of Payment ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other, specify: _____
12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature _____ Value_____	

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: ☐Yes ☐No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

EXHIBIT F
[Not applicable to this Contract]

Back to Agenda Back to Item

EXHIBIT G

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:	

Back to Agenda Back to Item

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:	Ron Dotzauer	Title:	CEO
Email:	contracts@strategies360.com	Phone #:	206.282.1990
Signature:		Date:	August 28, 2023

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 H
[Not applicable to this Contract]

Back to Agenda Back to Item

CalOptima Health Board Action Agenda Referral

Action To Be Taken September 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

14. Ratify the Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Fee-for-Service Physicians, Except Physicians Employed by UCI Health or the University of California, Irvine, to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

Contacts

Yunkyung Kim, Chief Operating Officer (714) 923-8834
Michael Gomez, Executive Director, Network Operations (714) 347-3262

Recommended Actions

1. Ratify a temporary, short-term supplemental Medi-Cal rate increases of up to 7.5% for contracted fee-for-service physicians, except physicians employed by UCI Health or the University of California, Irvine, for the period of July 1, 2023, through August 31, 2024;
2. Ratify contract amendments and policies and procedures that implement these temporary, short-term public health emergency transition supplemental Medi-Cal rate increases; and
3. Ratify unbudgeted expenditures from existing reserves in an amount up to $10.2 million to support the public health emergency transition supplemental payment program for all contracted fee-for-service physicians.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency (PHE) under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. On January 30, 2023, the White House announced that the federal PHE would end on May 11, 2023. Furthermore, the fiscal year (FY) 2023 federal budget ended the continuous Medicaid coverage that had been in place during the PHE after March 31, 2023, triggering the commencement of Medi-Cal redetermination activities on April 1, 2023.

Throughout these past three years, CalOptima Health's Board of Directors (Board) took actions to protect the health and safety of providers and members and to ensure continued access to health care for members, including authorizing supplemental payments to providers for services related to COVID-19. On February 2, 2023, the Board authorized up to $6 million to support redetermination efforts for members and members' communities. The transition out of the PHE after three years and the member redetermination process will place additional strains on the provider delivery system.

Discussion

CalOptima Health staff requests that the Board ratify the temporary, short-term supplemental rate increases to contracted fee-for-service physicians, except physicians employed by UCI Health or the University of California, Irvine, to support the delivery systems' transition out of the PHE and the

Back to Agenda

impacts of Medi-Cal redetermination. Staff propose to build upon the methodology the Board previously approved for COVID-19 supplemental payments.

Staff propose to designate the period of July 1, 2023, through August 31, 2024, as the transition period. This period is based on the first month of impact for Medi-Cal redetermination disenrollments. During this period, staff propose to provide a 7.5% increase from contracted rates in effect each month to physicians contracted with CalOptima Health for services provided to CalOptima Health Medi-Cal members enrolled in the CalOptima Health Community Network and CalOptima Direct. Medically necessary covered services provided on dates of service July 1, 2023, through August 31, 2024, would qualify for the temporary rate increase.

The following services are excluded from the short-term supplemental Medi-Cal payment increase:

- Pharmacy and non-pharmacy administered drugs (carved-out under Medi-Cal Rx);
- Long-term care services;
- Durable medical equipment, orthotics, prosthetics and other medical devices;
- Crossover claims;
- Other supplemental or directed payments, such as Proposition 56;
- Cost of administrative services providers; and
- Claims paid by letter of agreement.

Staff will monitor utilization and select quality metrics for access and quality care across the delivery system to monitor the impact of these funds during the transition period.

Fiscal Impact

The recommended actions will be funded by CalOptima Health reserves. An appropriation of up to $10.2 million in undesignated reserves will fund actions for all contracted fee-for-service physicians for the fourteen (14)-month period of July 1, 2023, through August 31, 2024.

Rationale for Recommendation

A temporary, short-term supplemental Medi-Cal payment program will support CalOptima Health's delivery system to ensure continuous access to care for members throughout the PHE transition period.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

N/A

/s/ Michael Hunn *08/31/2023*
Authorized Signature **Date**

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken September 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

15. Ratify a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Fee-for-Service Physicians Employed by UCI Health or the University of California, Irvine to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

Contacts

Yunkyung Kim, Chief Operating Officer (714) 923-8834
Michael Gomez, Executive Director, Network Operations (714) 347-3262

Recommended Actions

1. Ratify the temporary, short-term supplemental Medi-Cal rate increases of up to 7.5% for contracted fee-for-service physicians employed by UCI Health or the University of California, Irvine for the period of July 1, 2023, through August 31, 2024; and
2. Ratify contract amendments and policies and procedures to implement these temporary, short-term public health emergency transition supplemental Medi-Cal rate increases.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency (PHE) under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. On January 30, 2023, the White House announced that the federal PHE would end on May 11, 2023. Furthermore, the fiscal year (FY) 2023 federal budget ended the continuous Medicaid coverage that had been in place during the PHE after March 31, 2023, triggering the commencement of Medi-Cal redetermination activities on April 1, 2023.

Throughout these past three years, CalOptima Health's Board of Directors (Board) took actions to protect the health and safety of providers and members and to ensure continued access to health care for members, including authorizing supplemental payments to providers for services related to COVID-19. On February 2, 2023, the Board authorized up to $6 million to support redetermination efforts for members and members' communities. The transition out of the PHE after three years and the member redetermination process will place additional strains on the provider delivery system.

Discussion

CalOptima Health staff requests that the Board ratify the implementation of temporary, short-term supplemental rate increases to contracted fee-for-service physicians employed by UCI Health or the University of California, Irvine, to support the delivery systems' transition out of the PHE and the impacts of Medi-Cal redetermination. Staff propose to build upon the methodology the Board previously approved for COVID-19 supplemental payments.

Back to Agenda

Staff propose to designate the period of July 1, 2023, through August 31, 2024, as the transition period. This period is based on the first month of impact for Medi-Cal redetermination disenrollments. During this period, staff propose to provide a 7.5% increase from contracted rates in effect each month to physicians contracted with CalOptima Health for services provided to CalOptima Health Medi-Cal members enrolled in the CalOptima Health Community Network and CalOptima Direct. Medically necessary covered services provided on dates of service July 1, 2023, through August 31, 2024, would qualify for the temporary rate increase.

The following services are excluded from the short-term supplemental Medi-Cal payment increase:

- Pharmacy and non-pharmacy administered drugs (carved-out under Medi-Cal Rx);
- Long-term care services;
- Durable medical equipment, orthotics, prosthetics and other medical devices;
- Crossover claims;
- Other supplemental or directed payments, such as Proposition 56;
- Cost of administrative services providers; and
- Claims paid by letter of agreement.

Staff will monitor utilization and select quality metrics for access and quality care across the delivery system to monitor the impact of these funds during the transition period.

Fiscal Impact

The recommended actions will be funded by CalOptima Health reserves and are ratified through separate Board action. An appropriation of up to $10.2 million in undesignated reserves will fund actions for all contracted fee-for-service physicians for the fourteen (14)-month period of July 1, 2023, through August 31, 2024.

Rationale for Recommendation

A temporary, short-term supplemental Medi-Cal payment program will support CalOptima Health's delivery system to ensure continuous access to care for members throughout the PHE transition period.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

N/A

/s/ Michael Hunn *08/31/2023*
Authorized Signature **Date**

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken September 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

16. Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2022

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Peter Bastone, Chief Strategy Officer, (714) 246-8549

Recommended Actions

Authorize the following activities to secure Medi-Cal funds through the Voluntary Rate Range Intergovernmental Transfer (IGT) for Calendar Year 2022 (IGT 12):

1. Submission of a proposal to the California Department of Health Care Services (DHCS) to participate in IGT 12;
2. Pursuit of funding partnerships with the University of California-Irvine, First 5 Orange County (Children & Families Commission), the County of Orange, the City of Orange, the City of Newport Beach, and the City of Huntington Beach to participate IGT 12; and
3. Authorize the Chief Executive Officer to execute agreements with these entities and their designated providers (as necessary) to seek IGT 12 funds.

Background

The Voluntary Rate Range IGT program allows DHCS and CalOptima Health to secure additional Medi-Cal dollars for eligible Orange County entities. For each IGT transaction, DHCS identifies the estimated member months for rate categories (*e.g.*, adult, adult optional expansion, child, long term care, seniors and persons with disabilities, and whole child model) and provides the total amount available for Orange County to contribute through funding entities. To receive funds, entities provide a dollar amount to DHCS, which is then used to obtain a federal match. DHCS distributes the funds and the match to the eligible entities through CalOptima Health. To date, CalOptima Health has participated in eleven Voluntary Rate Range IGT transactions.

At the inception of the IGT program in 2010-2011, the CalOptima Health Board of Directors (Board) approved retaining 50% of the net proceeds. CalOptima Health retained the flexible funds to support the increase in new CalOptima Health members through additional enhanced benefits as well as contracted Medi-Cal services. In 2022, CalOptima Health reduced the amount of retained funds from 50% of net proceeds to a 2% administrative fee, which allows more funds to funnel to the community through its partners.

Discussion

On August 4, 2023, CalOptima Health received notification from DHCS regarding the IGT 12 opportunity with up to $49.9 million in contributions by entities in Orange County. CalOptima Health's proposal, along with the proposed funding entities' supporting documents, are due to DHCS no later than September 8, 2023.

Back to Agenda

The five eligible funding entities (University of California-Irvine, First 5 Orange County, the County of Orange, the City of Orange, and the City of Newport Beach) from the previous IGT transactions were contacted regarding their interest in participation in IGT 12. CalOptima Health also reached out to City of Huntington Beach, as it had recently inquired and expressed interest in IGT. Staff is in the process of developing a strategy to offer additional eligible entities with an opportunity to participate in any future IGT transactions.

The formal DHCS-required letter of interest from the six proposed funding entities was due to CalOptima by August 29, 2023, for submission to DHCS by September 8, 2023.

Board approval is requested to authorize staff to submit the proposal letter to DHCS for participation in IGT 12 and to authorize the Chief Executive Officer to enter into agreements with each of the six proposed funding entities submitting a letter of interest, or their designated providers, for the purpose of securing available IGT funds. Consistent with the most recent IGT transaction, CalOptima Health will retain an administrative fee of 2% of net proceeds, with the remaining net proceeds distributed to the funding entities.

Fiscal Impact
Staff anticipates the recommended action to be net budget neutral to CalOptima Health. The IGT 12 is expected to generate approximately $1.7 million to offset expenses for the administration of the IGT program.

Rationale for Recommendation
Submission of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Calendar Year 2022. It will increase dollars to funding entities in Orange County to support Medi-Cal services to CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Board Action
2. Department of Health Care Services Voluntary Rate Range IGT Program Notification Letter

/s/ Michael Hunn *08/31/2023*
Authorized Signature **Date**

Back to Agenda

Attachment 1 to the September 7, 2023 Board of Directors Meeting – Agenda Item 16

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
City of Huntington Beach	2000 Main Street	Huntington Beach	CA	92648
City of Newport Beach	100 Civic Center Drive	Newport Beach	CA	92660
City of Orange	300 E. Chapman Avenue	Orange	CA	92866
Children and Families Commission of Orange County (First 5 Orange County)	1505 E 17th Street, Suite 230	Santa Ana	CA	92705
Orange County Health Care Agency	405 W. 5th Street, 7th Floor	Santa Ana	CA	92701
Regents of the University of California, Irvine Medical Center (UCI Health)	333 City Blvd. West, Suite 200	Orange	CA	92868

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

August 4, 2023

Nancy Huang
Chief Financial Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: Calendar Year (CY) 2022 (January 1, 2022 – December 31, 2022) Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Ms. Huang:

The Calendar Year 2022 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service period of January 1, 2022, through December 31, 2022.

DHCS shall not direct the MCP's expenditure of payments received under the CY 2022 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

DHCS shall continue to administer all aspects of the IGT related to the CY 2022 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR CALENDAR YEAR 2022:

MCPs should refer to the estimated CY 2022 county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the CY 2022 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. Note that the estimated contribution (Non-Federal Share) amounts are based on CY 2022 capitation rates delivered to plans in July 2023, and actual member months (as of July 2023). Actual amounts may change based on finalized rates and updated enrollment information.

If an MCP elects to participate in the CY 2022 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

Soliciting Interest

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the CY 2022 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:

    1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on MCP letterhead.
    2. The MCP's primary contact information (name, title, e-mail address, mailing address, and phone number).

3. County/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for CY2022. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.
4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the CY 2022 Voluntary Rate Range Program Supplemental Attachment described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.

- The MCP must obtain a **letter of interest** from each governmental funding entity included in the MCP's proposal to DHCS. The highlighted sections in the letter of interest form provided in Attachment A (included below) must be filled out completely and printed on the participating governmental funding entity's letterhead. A separate letter of interest must be provided for each county or rating region. An individual who is authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest.

- The MCP must distribute to governmental funding entities and ensure submission to DHCS, either by the MCP or the governmental funding entity, of the **Calendar Year 2022 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by Friday**, September 8, 2023**.

- The proposals and letters of interest are due to DHCS ***by 5pm on* Friday, *September 8, 2023***. Please send a PDF copy of the required documents by e-mail to Vivian.Beeck@dhcs.ca.gov, Michael.Ha@dhcs.ca.gov, and Scott.Gale@dhcs.ca.gov. ***Failure to submit all required documents by the due date may result in exclusion from the CY 2022 Voluntary Rate Range Program.***

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their uncompensated contracted Medi-Cal costs and/or charges. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the CY 2022 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Vivian Beeck at (916) 345-8271 or by email at Vivian.Beeck@dhcs.ca.gov.

Sincerely,

DocuSigned by:
Michael Jordan
641B9785907E40F...

August 3, 2023

Michael Jordan
Staff Services Manager II
Financial Management Section C
Capitated Rates Development Division

Attachments

cc: Michael Hunn
Chief Executive Officer
CalOptima
505 City Parkway West
Orange, CA 92868

Vivian Beeck
Staff Services Manager I
Financial Management Section C
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

Michael Ha
Health Program Specialist
Financial Management Section C
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

Scott Gale
Associate Governmental Program Analyst
Financial Management Section C
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

ATTACHMENT A – LETTER OF INTEREST

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of _Insert Participating Funding Entity Name, a governmental entity, federal I.D. Number _Insert Federal Tax I.D. Number, in working with Managed Care Plan's Name (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2022 through December 31, 2022. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

_Insert Participating Funding Entity Name is willing to contribute approximately $_____ for the Calendar Year 2022 (January 1, 2022 – December 31, 2022) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:

(Please provide complete information including name, title, street address, e-mail address and phone number.)

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Signature

ATTACHMENT C

TOTAL AVAILABLE RATE RANGE

Voluntary Rate Range Program
Attachment C
January 1, 2022 - December 31, 2022

HPC	Health Plan Name	County	Rate Categories (1)	SIS/ UIS	Total MMs CY 22 (2)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Departmental Usage (3)	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund	Governmental Funding Entity Portion	Non Federal Share %
506	CalOptima	Orange	Child	SIS	3,520,004	83.10	$ 89.70	$ 6.60	$ -	$ 6.60	$ 23,232,027	$ 9,197,710	39.59%
506	CalOptima	Orange	Child	UIS	106,221	67.26	$ 72.61	$ 5.35	$ -	$ 5.35	$ 568,283	$ 443,331	78.01%
506	CalOptima	Orange	Adult	SIS	1,312,319	203.97	$ 217.29	$ 13.32	$ -	$ 13.32	$ 17,480,089	$ 7,515,596	43.00%
506	CalOptima	Orange	Adult	UIS	195,134	503.74	$ 536.63	$ 32.89	$ -	$ 32.89	$ 6,417,957	$ 4,262,295	66.41%
506	CalOptima	Orange	ACA Optional Expansion	SIS	3,556,781	300.55	$ 319.20	$ 18.65	$ 4.66	$ 13.99	$ 49,759,366	$ 4,975,937	10.00%
506	CalOptima	Orange	ACA Optional Expansion	UIS	294,319	743.54	$ 789.68	$ 46.14	$ 11.54	$ 34.60	$ 10,183,438	$ 5,174,422	50.81%
506	CalOptima	Orange	SPD	SIS	435,057	602.70	$ 638.28	$ 35.58	$ -	$ 35.58	$ 15,479,328	$ 6,767,627	43.72%
506	CalOptima	Orange	SPD	UIS	60,061	1,185.97	$ 1,256.00	$ 70.03	$ -	$ 70.03	$ 4,206,072	$ 2,900,629	68.96%
506	CalOptima	Orange	SPD/Full-Dual	SIS	75,272	216.63	$ 227.52	$ 10.89	$ -	$ 10.89	$ 819,712	$ 359,034	43.80%
506	CalOptima	Orange	SPD/Full-Dual	UIS	483	360.28	$ 378.40	$ 18.12	$ -	$ 18.12	$ 8,752	$ 6,442	73.61%
506	CalOptima	Orange	LTC (non-dual)	SIS	11,376	12,922.88	$ 13,273.23	$ 350.35	$ -	$ 350.35	$ 3,985,582	$ 1,745,685	43.80%
506	CalOptima	Orange	LTC (non-dual)	UIS	2,916	12,922.88	$ 13,273.23	$ 350.35	$ -	$ 350.35	$ 1,021,621	$ 934,863	91.51%
506	CalOptima	Orange	LTC/Full-Dual	SIS	-	8,505.92	$ 8,698.00	$ 192.08	$ -	$ 192.08	$ -	$ -	N/A
506	CalOptima	Orange	LTC/Full-Dual	UIS	87	8,505.92	$ 8,698.00	$ 192.08	$ -	$ 192.08	$ 16,711	$ 16,659	99.69%
506	CalOptima	Orange	Whole Child Model	SIS	137,953	1,727.07	$ 1,825.55	$ 98.48	$ -	$ 98.48	$ 13,585,611	$ 5,344,069	39.34%
506	CalOptima	Orange	Whole Child Model	UIS	3,608	1,727.07	$ 1,825.55	$ 98.48	$ -	$ 98.48	$ 355,315	$ 276,459	77.81%
506	**Health Plan Total**	**Health Plan Total**	**All COAs**		**9,711,591**	**281.45**	**$ 298.65**	**$ 17.21**		**$ 15.15**	**$ 147,119,864.00**	**$ 49,920,758**	**33.93%**

Footnotes:
1The supplemental payments (Maternity and BHT) are not included in the rate range calculation.
2 Mainstream Member Months are actuals for CY 22 MM effective as of July 2023.
3 Other Departmental Usages decreases available rate range funding.

Back to Agenda

Back to Item

Attachment B

Voluntary Rate Range Program Supplemental Attachment
Calendar Year 2022 (January 1, 2022 through December 31, 2022)

Provider's Legal Name:	
County:	
Health Plan:	

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than September 8, 2023.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2020-21 (July 1, 2020 - June 30, 2021).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other				$ -	$ -
Total	$ -	$ -	$ -	$ -	$ -

* Include payments received and anticipated to be received, for dates of service from July 1, 2020 - June 30, 2021.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2020 - June 30, 2021 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? ***(Yes / No)***

If **No**, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. We ask that a duly authorized representative formally attest to the following÷

(i) The legal name of the entity transferring funds:

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding:

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

(iv) Does the transferring entity have general taxing authority? ***(Yes / No)***

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. ***(Yes / No)***

5. Comments / Notes

Attestation by duly authorized representative:
Please print the Name (first & last), and Title: _____

Signature: _____

Back to Agenda Back to Item

CalOptima Health Board Action Agenda Referral

Action To Be Taken September 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

17. Approve Actions Related to Provision of Doula Services as a Covered Medi-Cal Benefit

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Marie Jeannis, Executive Director, Population Health, (714) 246-8591

Recommended Actions

1. Authorize implementation of new Medi-Cal Ancillary Services Contract template for doula services, effective September 1, 2023; and
2. Authorize reimbursement for doula services at 100% of the CalOptima Health Medi-Cal Fee Schedule.

Background

Doulas are birth workers who provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons. Doulas help their clients implement healthy behaviors, effectively communicate with their health care providers, develop birthing plans, and mentally and physically prepare for the experience of childbirth and breastfeeding. Research shows that individuals who are supported by a doula are less likely to experience postpartum depression, more likely to initiate and continue breastfeeding for a longer period and have improved birth outcomes.[1] Doula services align with the Department of Health Care Services' (DHCS) focus on improving health equity and maternal health outcomes. Doula services engage and motivate members to support quality outcomes for prenatal and postpartum visits, depression screenings, pregnancy immunizations, and well child visits for the infant.

In December 2022, DHCS released All-Plan Letter (APL) 22-031: Doula Services with guidance for the delivery of the new Medi-Cal benefit which started January 1, 2023. On June 1, 2023, the CalOptima Health Board of Directors (Board) approved Policy GG. 1707: Doula Services, which outlines services, eligibility criteria, doula qualifications, supervision requirements, provider enrollment and credentialing provisions, and billing requirements.

Doula services will be provided for CalOptima Health pregnant and postpartum members before, during, and after childbirth when recommended by a physician or other licensed practitioner of the healing arts.

CalOptima Health provides coverage for approximately 9,000 births per year. According to some estimates, it is anticipated that approximately 3% - 5% of Medi-Cal beneficiaries will utilize doula services in the first two years of implementation. Average use of doulas nationwide is approximately 6%, and Doulas of North America (DONA) estimates California doula utilization to be slightly higher at 9%.[2] CalOptima Health intends to promote doula services and increase the use of doula services to between 10% -12% in five years.

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[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/
[2] https://www.dona.org/ltminca-doulas/#:~:text=15%20percent%20of%20overall%20survey,during%20their%20labor%20and%20birth

Discussion

Contract, Eligibility and Covered Services

The doula benefit is a non-medical, assistive service to be provided either virtually, or at members' homes, office visits, hospital stays, and/or alternative birthing centers. Doula services do not include diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure. Covered services include help with housework, advice on infant care, lactation support, emotional support, and advocacy. Authorization is not required for doula services. However, eligibility for doula services requires a referral from the member's physician or other licensed practitioner of the healing arts.

DHCS has approved the proposed contract template, which outlines the terms and conditions, including the reimbursement structure, for CalOptima Health's doula provider network. Under the proposed template contract, eligible Medi-Cal fee-for-service and health network members will receive one initial visit, support during labor and delivery (including stillbirth, miscarriage, and abortion), up to eight additional doula visits between the prenatal and postpartum period, and up to two extended post-partum visits.

Upon Board approval, contracting staff will implement the attached Ancillary Services Contract, effective September 1, 2023, to support provider services for this newly covered benefit.

Comparative Analysis

CalOptima Health compared proposed doula reimbursement rates to CalOptima Health contracted obstetrician-gynecologist (OB/GYN) and ancillary provider rates, and other Medi-Cal Managed Care Plans' (MCPs) doula rates.

- **CalOptima Health Contracted OB/GYN Rates**
  According to DHCS, doula services will be reimbursed with the same billing codes used for OB/GYN visits. However, the doula benefit is an ancillary, non-professional service and OB/GYN visits are considered professional specialist services.

CPT Code	Description
Z1032	Initial Antepartum Visit (Extended initial visit 90 minutes)
Z1034	Antepartum Follow Up Visit (Prenatal Visit)
Z1038	Postpartum Follow Up Visit
59409	Vaginal Delivery (Doula support)
59612	Vaginal Delivery After Previous Caesarean Section (Doula support)
59620	Caesarean Section (Doula Support)

  CalOptima Health's current contract rates are 100% of the Medi-Cal Fee Schedule for ancillary services and 133% for specialist physician services, such as OB/GYN.

- **CalOptima Health Contracted Ancillary Provider Rates**
  Based on internal financial analysis of non-medical assistive services, reimbursing doula services at 100% of the Medi-Cal Fee Schedule results in an effective payment rate of $60/per hour for

doulas. This rate is higher than the reimbursement rate of $30-$38/hour for other personal care services, medical assistants, and emergency medical technicians.

- **Other MCP Doula Rates**
  CalOptima Health reviewed contracted doula rates for six local Medi-Cal MCPs. Four MCPs reimburse the doula benefit at 100% of the Medi-Cal Fee Schedule. Two of the MCPs reimbursing at 100% of the Medi-Cal Fee Schedule provided supplemental payment to support doula capacity building. Two MCPs reimbursed the doula benefit at rates above 100% of Medi-Cal Fee Schedule.

Proposed Reimbursement for Doula Services
CalOptima Health proposes to contract with doulas at 100% of the CalOptima Health Medi-Cal Fee Schedule. Additionally, on June 1, 2023, the Board approved a temporary, short-term supplemental Medi-Cal rate increase of up to 7.5% from contracted rates in effect each month for medically necessary covered services provided by contracted ancillary providers on dates of service July 1, 2023, through August 31, 2024. Ancillary providers who are eligible for the temporary increase will receive a total reimbursement rate of 107.5% of the CalOptima Health Medi-Cal Fee Schedule for eligible services through August 31, 2024. Furthermore, pursuant to the enacted FY 2023-24 State Budget, effective no sooner than January 1, 2024, CalOptima Health is expected to increase doula reimbursement rates to the equivalent of 87.5% of the Medicare fee schedule. These rate enhancements will support capacity building and ensure CalOptima Health's members have continued access to quality care.

Capacity Building Strategy
CalOptima Health has approximately 9,000 births per year of which 50% are for members in the delegated health networks. CalOptima Health recognizes the need to support the growth of doulas to serve all members regardless of network.

To quickly build CalOptima Health's doula capacity, staff will implement the following one-time startup doula incentive payments:

- $550 for contracting with CalOptima Community Network (CCN); and
- $350 per additional health network contract.

A doula can potentially earn an additional $3,000 by contracting with CCN and all seven health networks. CalOptima Health proposes allocating up to $60,000 in startup incentives to support approximately 20 doulas contracting across all health networks.

In a recent DHCS doula survey, doulas found technical requirements such as billing and enrollment processes challenging. In addition to contracting with individual doula providers, CalOptima Health is in the process of vetting doula networks that can streamline certain administrative processes for doulas, including credentialing, contracting, service documentation, billing, and client matching. Staff will also continue to work with doulas, local stakeholders, and community-based organizations to support doula training and workforce development.

Fiscal Impact

Back to Agenda

The CalOptima Health Fiscal Year (FY) 2023-24 Operating Budget included approximately $530,000 for the doula services benefit. Staff will monitor actual cost and utilization of the new benefit as it is implemented.

Pursuant to the enacted FY 2023-24 State Budget, effective no sooner than January 1, 2024, CalOptima Health is expected to increase doula reimbursement rates to the equivalent of 87.5% of the Medicare fee schedule. CalOptima Health anticipates additional funding from the state will be sufficient to cover this additional expense.

Funding of up to $60,000 for one-time start-up doula provider incentives is included as part of the Health Education & Disease Management budget under the CalOptima Health FY 2023-24 Operating Budget.

Rationale for Recommendation

Staff requests approval of the proposed Ancillary Services Contract template and reimbursement terms for doula services to ensure access to this newly covered benefit and support improve quality health outcomes for pregnant and postpartum members and their infants.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. Proposed Ancillary Services Contract for Doula Services
3. APL 22-031: Doula Services
4. CalOptima Health Policy GG.1707: Doula Services

/s/ Michael Hunn *08/31/2023*

Authorized Signature **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima Health Medi-Cal Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Care Medical Group	600 City Parkway West Ste. 800	Orange	CA	92868
CHOC Health Alliance	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Health Services	7631 Wyoming St. Ste. 202	Westminster	CA	92683
HPN Regal Medical Group	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Kaiser Permanente	393 E. Walnut St.	Pasadena	CA	91188
Noble Mid-Orange County	5785 Corporate Ave.	Cypress	CA	90630
Optum Care Network -Arta	3390 Harbor Blvd., Ste. 100	Costa Mesa	CA	92626
Optum Care - Monarch	1 Technology Dr.	Irvine	CA	92618
Optum Care -Talbert	3390 Harbor Blvd. Ste. 100	Costa Mesa	CA	92626
Prospect Medical Group	600 City Parkway West Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

Back to Agenda Back to Item

ANCILLARY SEVICES CONTRACT

between

ORANGE COUNTY HEALTH AUTHORITY DBA CAL OPTIMA HEALTH

and

_____

TABLE OF CONTENTS

ANCILLARY SERVICES CONTRACT

This Ancillary Services Contract (the "**Contract**") is effective as July 1, 2023 ("**Effective Date**") by and between Orange County Health Authority, a public agency dba CalOptima Health ("**CalOptima**"), and **@@Provider Name@@** ("**Provider**"). CalOptima and Provider may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

1. 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.

2. CalOptima contracts with the California Department of Health Care Services ("**DHCS**") to arrange and pay for the provision of health care services to certain Medi-Cal-eligible beneficiaries in Orange County enrolled in CalOptima's Medi-Cal program ("**Program**").

3. Provider provides the items and services described in this Contract and has all certifications, licenses, and permits necessary to furnish such items and services.

4. 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

Capitalized words or phrases not otherwise defined in this Contract shall have the meanings set forth below:

1.1. "**Authorization**" or "**Authorized**" means the written or telephonic approval of CalOptima or its delegate for the provision or referral of Covered Services, other than emergency services, in accordance with CalOptima Policies and this Contract.

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. "**CCS Eligible Condition(s)**", means a physically handicapping condition, as defined in Title 22 C.C.R. Sections 41515.2 through 41518.9.

1.4. "**COD**" means a direct program CalOptima administers for CalOptima beneficiaries not enrolled in a Health Network. COD consists of two components:

1.4.1. COD Members who are assigned to a Community Network in accordance with CalOptima Policies.

1.4.2. "**COD-Administrative**" provides services to Members who reside outside of CalOptima's service area, are transitioning into a Heath Network, have a Medi-Cal Share of Cost, or are eligible for both Medicare and Medi-Cal.

1.5. "**CalOptima Policies**" means the policies and procedures established by CalOptima relevant to this Contract, including those set forth in CalOptima's Provider Manual, provider newsletters, or other written communications to providers, and as amended from time to time at the sole discretion of CalOptima. CalOptima Policies include network management, quality management, utilization review, credentialing, peer review, claims billing and reimbursement, member rights and responsibilities, and grievances and appeals.

1.6. "**CCS-Paneled Providers(s)**" means any of the following providers when used to treat Members for a CCS 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.

1.7. "**CCS Program**" means the State public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS Eligible Conditions.

1.8. "**Claim**" means a request for payment submitted by Provider to CalOptima.

1.9. "**Clean Claim**" means a Claim that has no defects or improprieties, contains all required supporting documentation, passes all system edits, does not require any additional reviews by medical staff to determine appropriateness of services provided under the Program, and otherwise complies with the terms of this Contract and CalOptima Policies.

1.10. "**Community Network**" means CalOptima's direct health network that serves members who are enrolled in it pursuant to CalOptima Policies. Community Network Members are assigned to primary care providers ("**PCPs**") as their medical home, and their care is coordinated through the PCP.

1.11. "**Compliance Program**" means the program, including the compliance manual, code of conduct and CalOptima Policies, developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of CalOptima's Board of Directors, employees, contractors, and providers comply with Laws and ethical standards. The Compliance Program includes CalOptima's fraud, waste, and abuse plan.

1.12. "**COB**" refers to the coordination of benefits determinations of the order of financial responsibility that applies when two or more health benefit plans provide coverage of items and services for an individual.

1.13. "**Covered Services**" means those health care items, drugs, and services that a Member is entitled to receive under the Member's Program and are identified in Attachment A. Covered Services must generally be Authorized in accordance with CalOptima's Policies, including its utilization management program, with the exception of emergency services.

1.14. "**Doula**" means birth workers who provide health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during, and after childbirth (perinatal period), including support during miscarriage, stillbirth, and abortion. Doulas are not licensed or clinical providers and do not require physician supervision.

1.15. "**Encounter Data**" means the record of a Member receiving any items(s) or service(s) provided through Medicaid under a prepaid, capitated or any other risk basis payment methodology submitted to CMS. The Encounter Data records shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by Regulators.

1.16. "**Government Contract(s)**" means the 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 Program.

1.17. "**Health Network**" means a physician group, physician-hospital consortium, or health care service plan, such as an HMO, that contracts with CalOptima to provide items and services to non-COD Members on a capitated basis.

1.18. "**Laws**" means any local, State, or federal statute, regulation, rule, or executive or agency order applicable to this Contract, including Regulators' operational and other instructions related to the coverage, payment, and/or administration of Programs.

1.19. "**Licenses**" means all licenses and permits that Provider is required to have in order to participate in the Programs and/or furnish the items and/or services under this Contract.

1.20. "**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).

1.21. "**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 T22 CCR § 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 includes the standards in 42 USC § 1396d(r) and Welfare & Institutions Code § 14132(v).

1.22. "**Medicare**" means the federal health insurance program defined in Title XVIII of the Federal Social Security Act and regulations promulgated thereunder.

1.23. "**Member**" means any person who is eligible to receive benefits from and is enrolled in a Program.

1.24. "**Overpayment**" means a payment Provider receives that, after applicable reconciliation, Provider is not entitled to receive or retain pursuant to Laws, Government Contracts, and/or this Contract.

1.25. "**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.

1.26. "**Participation Status**" means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in any federal and/or State health care programs and/or

has a felony conviction (if applicable), as specified in the Compliance Program and CalOptima Policies.

1.27. "**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.

1.28. "**Regulators**" mean those government agencies that regulate and oversee CalOptima, including the Department of Health and Human Services ("**HHS**") Inspector General, the Centers for Medicare and Medicaid Services ("**CMS**"), the California Department of Health Care Services ("**DHCS**"), the California Department of Managed Health Care ("**DMHC**"), the Comptroller General, and other government agencies that have authority to set standards and oversee the performance of the Parties.

1.29. "**State**" means the State of California.

1.30. "**Subcontract**" means a contract entered into by Provider or a Subcontractor with a Subcontractor to the extent, permitted under this Contract.

1.31. "**Subcontractor**" means a person or entity who has entered into a Subcontract with Provider or another Subcontractor for the purposes of filling Provider's obligations under this Contract.

1.32. "**Whole Child Model Program**" means CalOptima's 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
PROVIDER OBLIGATIONS

2.1 Covered Services.

2.1.1 Provider is a Doula and shall furnish the Covered Services that are Authorized by CalOptima and listed in Attachment A to eligible Members. Provider shall furnish such items and services in a manner satisfactory to CalOptima in accordance with Laws and CalOptima Policies.

2.1.2 Throughout the Term, Provider shall maintain the quantity and quality of its services and personnel in accordance with the requirements of this Contract, Laws, and CalOptima Policies.

2.2 Licensure. Provider represents and warrants that it has, and shall maintain during the Term, all valid and active Licenses necessary to render Covered Services.

2.3 Regulatory Approvals. Provider represents and warrants that it has, and shall maintain during the Term, applicable Medi-Cal provider and/or supplier numbers.

2.4 Good Standing. Provider represents and warrants that it is, and shall remain during the Term, in good standing with State licensing boards applicable to its business, DHCS, CMS, and the HHS Officer of Inspector General, as applicable. Provider agrees to furnish CalOptima any and all correspondence with and notices from these agencies regarding investigations or the issuance of criminal, civil, and/or administrative sanctions (threatened or imposed) related to licensure, fraud,

and abuse (execution of grand jury subpoena, search and seizure warrants, etc.), and/or Participation Status.

2.5 Geographic Coverage Area. Provider shall provide Covered Services in all areas of Orange County, California.

2.6 Eligibility Verification. Provider shall verify a Member's eligibility for the Program benefits upon receiving request for Covered Services. For Members share-of-cost ("**SOC**") obligations, Provider shall collect SOC in accordance with CalOptima Policies and Laws.

2.7 Notices and Citations. Provider shall notify CalOptima in writing of any report or other writing from any State or federal agency or accreditation organization that contains a citation, sanction, and/or disapproval of Provider for a failure to meet any material requirement of State or federal law or accreditation organization standard.

2.8 Professional Standards. All Covered Services under this Contract shall be provided or arranged by duly licensed, certified, or otherwise authorized professional personnel in manner that (i) meets the cultural and linguistic requirements of this Contract, Laws, and CalOptima Policies; (ii) within professionally recognized standards of practice at the time of treatment; and (iii) in accordance with the provisions of CalOptima's utilization management ("**UM**") program.

2.9 Marketing Requirements. Provider shall comply with CalOptima's marketing guidelines relevant to the applicable Program(s) and marketing Laws.

2.10 Disclosure of Provider Ownership. Provider shall provide CalOptima with the following information in Attachment E, as applicable: (i) names of all officers of Provider's governing board; (ii) names of all owners of Provider; (iii) names of stockholders owning more than five percent (5%) of the stock issued by Provider; and (iv) names of major creditors holding more than five percent (5%) of the debt of Provider. Provider shall notify CalOptima immediately of any changes to the information included by Provider in Attachment E.

2.11 Provider Agreement to Extend Terms and Rates. Provider agrees to extend to Health Networks the same terms contained in this Contract, including rates, for Covered Services provided to Members enrolled in Health Networks. Provider agrees to contract with a Health Network(s) upon the request of a Health Network(s).

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 quality management and improvement ("**QMI**") program and that it shall participate in QMI program, as required by CalOptima. Such activities may include the provision of requested data and the participation in assessment and performance audits and projects (including those required by Regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members. Provider shall cooperate with CalOptima and Regulators in any complaint, appeal, or other review of Covered Services (e.g., medical necessity) and shall accept as final all decisions regarding disputes over Covered Services by CalOptima or such Regulators, as applicable, and as required under the Program. Provider shall also allow CalOptima to use performance data for quality and reporting purposes including quality improvement activities, public reporting to consumers, and performance data reporting to Regulators, as identified in CalOptima Policies.

2.13 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 Regulator determines that corrective action is needed with regard to any Provider duty under this Contract; and/or (iv) revoke the delegation of any duty, if Provider fails to meet CalOptima standards in the performance of that duty. Provider shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with the Laws and/or CalOptima Policies.

2.14 Transfer of Care. Upon request by a Member, Provider shall assist the Member in the orderly transfer of Member's medical care to another provider. In doing so, Provider shall make available to the new provider copies of the medical records, patient files, and other pertinent information, including information maintained by any Subcontractor, necessary for the efficient medical case management of Member. In no circumstance shall a Member be billed for this service.

2.15 Linguistic and Cultural Sensitivity Services. Provider shall comply with CalOptima Policies and Laws related to linguistic and cultural sensitivity. CalOptima will provide cultural competency, sensitivity, and diversity training. Provider shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Provider shall in its policies, administration, and services: (i) honoring Members' beliefs, traditions, and customs; (ii) recognize individual differences within a culture; (iii) create an open, supportive, and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, foster in Provider staff attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Provider shall fully cooperate with CalOptima in the provision of cultural and linguistic services provided by CalOptima for Members receiving services from Provider. Provider shall provide translation of written materials in the threshold languages identified by CalOptima at no higher than the sixth (6^{th}) grade reading level.

2.16 Provision of Interpreters. Provider shall ensure that 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, including Attachment B, CalOptima Policies, and Laws.

Interpreters shall be used where needed and when technical, medical, or treatment information is to be discussed. Provider shall not require a Member to use friends or family as interpreters. However, a family member may be used when the use of the family member or friend: (i) is requested by a Member; (ii) will not compromise the effectiveness of service; (iii) will not violate a Member's confidentiality; and (iv) Member is advised that an interpreter is available at no cost to the Member.

2.17 CalOptima's Compliance Program and Other Guidance. Provider and its employees, board members, owners, and/or Subcontractors furnishing services under this Contract ("**Provider's Agents**") shall comply with the requirements of the Compliance Program, including CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Program and Code of Conduct available to Provider, and Provider shall make them available to Provider's Agents.

2.18 Equal Opportunity. Provider and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Provider and its Subcontractors will take affirmative action to ensure that qualified applicants are employed and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. As applicable, Provider and its Subcontractors will comply with all provisions of and furnish and post all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212), and of the Federal Executive Order No. 11246, as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR Part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

Provider and its Subcontractors will permit access to their books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

If Provider or its Subcontractors do not comply with the provisions herein or with any applicable federal rules, regulations, or orders referenced herein, 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 and remedies provided under Laws.

Provider and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor or other Laws. Provider and its Subcontractors will take such action with respect to any subcontract or purchase order as directed by the Director of the Office of Federal Contract Compliance Programs or DHCS as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that if Provider and its Subcontractors become involved in or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Provider and its Subcontractors may request in writing to DHCS, 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.

2.19 Compliance with Applicable Laws and Policies. Provider shall observe and comply with all Laws. 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 also shall comply with all applicable CalOptima Policies. Provider agrees to include the requirements of this section in its Subcontracts.

2.20 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, and Acquired Immune Deficiency Syndrome), 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 § 12900 *et seq*.) and the applicable regulations promulgated thereunder, (2 CCR § 7285.0 *et seq*.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code § 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Provider and 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.

2.21 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 § 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC § 794) (nondiscrimination under federal grants and programs); 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving federal financial assistance); 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); 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); Government Code § 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code § 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: (i) denying any Member any Covered Services or availability of a Provider, (ii) providing to a Member any Covered Service that 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, (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (iv) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, or (v) treating a Member differently 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-Members. 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 that may, under some circumstances, be associated with disability in that person's offspring, but that causes no adverse effects on the carrier. Such genetic handicap shall include 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 Policies.

2.22 Reporting Obligations. In addition to any other reporting obligations under this Contract, Provider shall submit such reports and data relating to services under this Contract as required by CalOptima, including to comply with the requests from Regulators. CalOptima shall reimburse Provider for reasonable costs for producing and delivering such reports and data.

2.23 Subcontract Requirements. If permitted by the terms of this Contract, Provider may subcontract for certain functions covered by this Contract, subject to the requirements of this Contract. Subcontracts shall not terminate the legal liability of Provider under this Contract. Provider must ensure that all Subcontracts are in writing, bind Subcontractors to all applicable provisions under this Contract, and incorporate all required provisions under this Contract or applicable Government Programs. Any Provider obligation under this Contract shall be deemed to include applicable Subcontractors. Provider shall make all Subcontracts available to CalOptima or its Regulators upon request. Provider is required to inform CalOptima of the name and business addresses of all Subcontractors. Additionally, Provider shall require that all Subcontracts relating to the provision of Covered Services include provisions requiring the Subcontractor to do the following :

2.23.1 Make all books and records related to this available at all reasonable times for inspection, examination or copying by CalOptima or Regulators in accordance with Government Contract requirements and Laws.

2.23.2 Maintain such books and records (i) in accordance with the general standards applicable to such books and records and any record requirements in this Contract and CalOptima Policies; (ii) at the Subcontractor's place of business or at such other mutually agreeable location in California.

2.23.3 Notify Provider of any investigations into Subcontractors' professional conduct or any suspension of or comment on a Subcontractor's Licenses, whether temporary or permanent.

2.23.4 Comply with the Compliance Program.

2.23.5 Comply with Member financial and hold harmless protections in this Contract.

2.24 Fraud and Abuse Reporting. Provider shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 § 455.2, relating to the rendering of Covered Services, whether the cases relate to 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.

2.25 Participation Status. Provider shall have policies and procedures in place to verify the Participation Status of Provider's Agents. In addition, Provider represents and warrants that:

2.25.1 Provider and Provider's Agents shall meet CalOptima's Participation Status requirements at all times during the Term.

2.25.2 Provider shall immediately disclose to CalOptima any pending investigation involving, or any determination of, suspension, exclusion or debarment from a State or federal program of Provider or Provider's Agents occurring and/or discovered during the Term.

2.25.3 Provider shall take immediate action (i) to prevent any Provider's Agent that does not meet Participation Status requirements from furnishing items or services related to this Contract to Members, and (ii) take any other actions required by Regulators, Government Contracts, or Lawss.

2.25.4 Provider shall ensure the obligations of this Section 2.25 are included in Subcontracts.

2.25.5 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 Laws.

2.26 Credentialing and Recredentialing. Prior to providing any Covered Services and throughout the Term, Provider and all Subcontractors shall be credentialed and periodically recredentialed by CalOptima and fully cooperate with CalOptima credentialing and recredentialing procedures as required by CalOptima Policies and Laws.

2.27 Physical Access for Members. Provider's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990 ("**ADA**"), and Provider and its Subcontractors shall ensure access for the disabled, which includes compliance with the ramps, elevators, restrooms, designated parking spaces, and drinking water requirements under the ADA.

2.28 Smoke Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994 ("**Pro Children Act**"), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Provider certifies that it will comply with the requirements of the Pro Children Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Pro Children Act. The prohibitions herein are effective December 26, 1994. Provider further agrees to ensure that this certification is included in any Subcontracts entered into that provide for children's services as described in the Pro Children Act.

2.29 Member Rights. Provider shall ensure that each Member's rights, as set forth in Laws and CalOptima Policies, are fully respected and observed.

2.30 Electronic Transactions. Provider shall use best efforts to participate in the exchange of electronic transactions with CalOptima, including electronic claims submission, verification of eligibility and enrollment through electronic means, and submission of electronic prior authorization transactions in accordance with CalOptima Policies.

2.31 Advance Directives. Provider shall comply with Laws regarding Advance Directives. Provider shall not discriminate against any Member on the basis of that Member's Advance Directive status. Nothing in this Contract shall be interpreted to require a Member to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of

services. "**Advance Directive**" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law.

2.32 Whole Child Model Program Compliance. If Provider is a CCS-authorized provider, then in the provision of CCS Services to Members, Provider shall follow CCS Program guidelines, including CCS Program regulations, and where CCS clinical guidelines do not exist, Provider will use evidence-based guidelines or treatment protocols that are medically appropriate to the Member's CCS Eligible Condition.

2.33 CCS Provider Compliance.

2.33.1 Only CCS-Paneled Providers may treat a Member's CCS Eligible Condition.

2.33.2 If Provider is a CCS-Paneled Provider, Provider agrees to provide services for the Whole Child Model Program in accordance with CalOptima Policies.

2.33.2.1 Effective when the CalOptima Whole Child Model Program becomes effective, Provider shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services under this Contract for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

2.33.2.2 To ensure consistency in the provision of CCS Covered Services, Provider shall use all current and applicable CCS Program guidelines, including CCS Program regulations. When applicable CCS clinical guidelines do not exist, Provider shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Members' CCS Eligible Condition.

2.34 Provider Terminations. If a Subcontract terminates, Provider shall ensure that there is no disruption in services provided to Members.

2.35 Government Claims Act. Subject to Section 9.13 Provider shall ensure that Provider and Provider's Agents comply with the applicable provisions of the Government Claims Act (California Government Code section 900 *et seq*.).

2.36 Certification of Document and Data Submissions. All data, information, and documentation provided by Provider to CalOptima pursuant to this Contract shall be accompanied by a certification statement on the Provider's letterhead, signed by Provider's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such officer), attesting that based on the best information, knowledge, and belief, the data, documentation, and information are accurate, complete, and truthful.

ARTICLE 3
FUNCTIONS AND DUTIES OF CALOPTIMA

3.1 Payment. CalOptima shall pay Provider for Covered Services provided to Members as provided in CalOptima Policies and Attachment C. Provider agrees to accept the compensation set forth in Attachment C as payment in full from CalOptima for such Covered Services. Notwithstanding the foregoing, Provider may also collect other amounts (e.g., copayments, deductibles, and/or third-party liability payments) where expressly authorized under the Program(s) and Laws.

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 Attachment C, CalOptima Policies, and Laws.

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 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 Laws.

4.5 Coordination of Benefits. Provider shall coordinate benefits with other programs or entitlements recognizing where CalOptima is not the primary coverage, in accordance with Program requirements. Provider acknowledges that Medi-Cal is a payor of last resort.

4.6 Member Financial Protections. Provider and its Subcontractors shall comply with Member financial protections as follows:

4.6.1 Provider agrees to indemnify and hold Members harmless from all efforts to seek compensation from Members for Covered Services that are CalOptima's payment responsibility under this Contract.

4.6.2 In no event, including non-payment by CalOptima, CalOptima's or Provider's insolvency, or breach of this contract by CalOptima, shall Provider, or any of its Subcontractors, bill, seek compensation,, collect reimbursement, or have any recourse against the State 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 the Program and Laws.

4.6.3 This provision does not prohibit Provider or its Subcontractors from billing and collecting payment for non-Covered Services if the 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 Provider invoicing or balance billing a Member for the difference between the Provider's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Provider or take other action as provided in this Contract or allowed under Laws.

4.6.5 This Section 4.7 shall survive 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. Provider shall ensure the substance of this Section 4.7 is included in all of Subcontracts.

4.7 Overpayments. 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 receipt of notice of an Overpayment identified by CalOptima or any other entity.

4.8 Offset. If CalOptima determines that an Overpayment has occurred, CalOptima shall have the right to recover such amounts from Provider by offset from current or future amounts due from CalOptima to Provider under this Contract or any other arrangement between the Parties, after giving Provider notice and an opportunity to return/pay such amounts. This right to offset shall include:

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 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 attorneys' fees, that are related to or arise out of the negligent or willful performance or non-performance by the indemnifying Party of any functions, duties, or obligations of the Party under this Contract. This Section 5.1 shall survive the termination of the Contract.

5.2 Provider Professional Liability. Provider, at its sole cost and expense, shall ensure that it and Subcontractors maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts that of one million dollars ($1,000,000) per incident/three million dollars ($3,000,000) aggregate per year. CalOptima is to be named as an additional insured, and the insurance will evidence primary and non-contributory coverage. Subrogation rights against CalOptima are to be waived.

5.3 Provider Commercial General Liability/Commercial Crime Liability/Automobile Liability. Provider at its sole cost and expense shall maintain such policies of commercial general liability, commercial crime liability, and automobile liability and other insurance as shall be necessary to

insure it and its business address(es), customers (including Members), employees, agents, and representatives against any claim or claims for damages arising by reason of (i) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder, (ii) the use of any property of the Provider, and (iii) activities performed in connection with the Contract, with minimum coverage of:

5.3.1 Commercial General Liability of $1,000,000 per incident/$2,000,000 aggregate per year.

5.3.2 Commercial Crime Liability of $250,000 aggregate per year.

5.3.3 Automobile Liability of $500,000 combined single limit.

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. Such insurance will be secured and maintained at Provider's own expense. All above insurance shall be provided by an insurer:

5.5.1 With an A.M. Best rating of A-VII or better; and

5.5.2 "Admitted" to do business in the State, an insurer approved to do business in the State by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers, or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code § 12180.7.

5.6 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. Provider shall not of its own initiative cause such insurances as addressed in this Article 5 to be canceled or materially changed during the Term.

5.8 Certificates of Insurance. Prior to execution of this Contract, Provider shall provide Certificates of Insurance to CalOptima showing the insurance coverage required under this Article 5 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. Provider and its Subcontractors shall allow CalOptima, Regulators, and/or their duly authorized agents and representatives access to books and records related to services provided under the Contract, including medical records, contracts, documents, and electronic systems. Provider shall be given advance notice of such visit in accordance with

CalOptima Policies. Such access shall include the right to directly observe all aspects of Provider's operations and to inspect, audit, and reproduce all records and materials and to verify Claims and reports submitted under this Contract. Provider shall maintain records in chronological sequence and in an immediately retrievable form in accordance with the Laws applicable to such record keeping. If DHCS, CMS, or the HHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the HHS 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 and its Subcontractors from participation in the Medi-Cal program; seek recovery of payments made to Provider; and impose other sanctions, and CalOptima may terminate this Contract immediately due to fraud.

6.2 Medical Records. Provider and its Subcontractors shall establish and maintain for each Member who has obtained Covered Services medical records organized in a manner to contain such demographic and clinical information as necessary to provide and ensure accurate and timely documentation as to the medical problems and Covered Services provided to the Member. Such medical records shall be consistent with Laws, Program requirements, and CalOptima Policies and shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, Provider. Such medical records shall be in such a form as to allow trained health professionals, other than the Provider, to readily determine the nature and extent of the Member's medical problem and the services provided, and to permit peer review of the care furnished to the Member.

6.3 Records Retention. Provider shall maintain books and records in accordance with the time and manner requirements set forth in Laws and Programs, including as identified Attachment D.

6.4 Audit, Review and/or Duplication. Audit, review and/or duplication of data or records shall occur within regular business hours and shall be subject to Laws concerning 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 Laws governing the confidentiality of Member medical and other information. Provider further agrees:

6.5.1 Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"). Provider shall comply with HIPAA requirements, including the Health Information Technology for Economic and Clinical Health ("**HITECH**") Act, the California Confidentiality of Medical Information Act ("**CMIA**"), and the implementing regulations of those laws (collectively "**HIPAA Requirements**"). 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 Laws. Provider shall protect from unauthorized disclosure all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.5.3 Declaration of Confidentiality. If Provider and 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, and/or CMS, as applicable.

6.6 Data Submission. Provider shall submit to CalOptima complete, accurate, reasonable, and timely provider data, Encounter Data, and other data and reports needed by CalOptima in order for CalOptima to meet its reporting requirements to Regulators, including DHCS, and as set forth in CalOptima Policies.

ARTICLE 7
TERM AND TERMINATION

7.1 Term. The term of this Contract shall begin on the Effective Date and continue in effect for five (5) years ("**Initial Term**"). The Contract then shall automatically renew for five (5) one (1)-year terms (each a "**Renewal Term**"), unless otherwise terminated under this Article 7 or directed by CalOptima's Board of Directors. The Initial Term and any Renewal Terms together constitute the "**Term**" of this Contract.

7.2 Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Provider or any Subcontractor (a) has failed to perform its contracted duties and responsibilities in a timely and proper manner including service procedures and standards identified in this Contract, (b) has committed acts that discriminate against Members on the basis of their health status or requirements for health care services; (c) has not provided Covered Services in the scope or manner required under the provisions of this Contract; (d) has engaged in prohibited marketing activities; (e) has failed to comply with the Compliance Program; or (f) has materially breached any other covenant, condition, or term of this Contract (each a "**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. If the Termination for 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 Section 7.2 are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. Provider shall not be relieved of its liability to CalOptima for damages sustained by virtue of 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's 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's Agents in their capacities with the Provider by any Federal or State licensing agency; (iv) Provider's failure to comply with Participation Status requirements; (v) Provider has committed fraud, waste, or abuse; (vi) Provider and/or any of its insolvency (vii) termination or non-renewal of any Government Contract; (viii) the withdrawal of HHS'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 Regulators or termination of the Section 1915(b) waiver, CalOptima shall immediately transmit such notice to Provider. If Provider or a Subcontractor becomes insolvent, Provider shall immediately notify CalOptima. In the event of the filing of a petition for bankruptcy by or against Provider or a principal Subcontractor, Provider shall assure that all tasks related to the Contract or the Subcontract are performed in accordance with the terms of the Contract.

7.4 Termination Without Cause. Either Party may terminate this Contract without cause upon ninety (90) days' prior written notice to the other Party.

7.5 Rate Adjustments. CalOptima may adjust the payment rates during the Term to account for implementation of federal or State laws or regulations; changes in the State budget, Government Contract(s) or Regulators' policies; and/or changes in in the scope of Covered Services. CalOptima shall provide notice thereof to Provider as soon as practicable of any such changes.

7.6 Obligations Upon Termination. Upon termination of this Contract, Provider shall continue to provide authorized Covered Services to Members who retain eligibility and who are under the care of Provider at the time of such termination until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. Payment for services under this Section 7.6 shall be at the contracted rates in effect under the Contract immediately prior to termination. Prior to the termination or expiration of this Contract and upon request by CalOptima or one of its Regulators to assist in the orderly transfer of Members' medical care, Provider shall make available to CalOptima and/or such Regulators, copies of any pertinent information, including information maintained by Provider and any Subcontractor necessary for the 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 have not yet been completed, and the time period covered by the Authorization has not yet expired.

7.7 Approval By and Notice to Regulators. Provider acknowledges that this Contract and any amendments thereto are subject to the approval of DHCS. CalOptima and Provider shall notify DHCS of amendments to, or termination of, this Contract. Notice shall be given by first-class mail, postage prepaid to the attention of the DHCS contracting officer for the pertinent Program. Provider acknowledges and agrees that any amendments shall be consistent with requirements relating to submission to DHCS for approval.

ARTICLE 8
GRIEVANCES AND APPEALS

8.1 Provider Grievances. CalOptima has established a fast and cost-effective 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 Program. Provider shall resolve any complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract prior to proceeding to arbitration under Section 9.13.

8.2 Member Grievances and Appeals. Provider agrees to cooperate in the investigation of any Member grievances, complaints, and appeals and be bound by CalOptima's decisions and, if applicable, State and/or federal hearing decisions or any subsequent appeals.

ARTICLE 9
GENERAL PROVISIONS

9.1 Assignment and Assumption. This Contract is not assignable by the Provider, either in whole or in part, without the prior written consent of CalOptima, which may be withheld in CalOptima's sole and absolute discretion. For purposes of this Section 9.1 and this Contract, assignment includes: (a) the change of more than fifty percent (50%) of the ownership or equity interest in

Provider (whether in a single transaction or in a series of transactions), (b) the change of more than fifty percent (50%) of the directors or trustees of Provider, (c) the merger, reorganization, or consolidation of Provider with another entity when Provider is not the surviving entity, and (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 or entity.

9.2 Documents Constituting Contract. This Contract, including its attachments, addenda, exhibits, and amendments and all CalOptima Policies applicable to Covered Services (and any amendments thereto) shall constitute the entire agreement between the Parties and shall supersede and terminate any previous agreements between the Parties. 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 not expressly set forth herein shall be of no further force, effect or legal consequence after the Effective Date.

9.3 Amendments. CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in 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 ("**Regulatory Change**"). CalOptima shall notify Provider in writing of such Regulatory Changes immediately and in accordance with applicable federal and/or State requirements, and, if CalOptima modifies the Contract, Provider shall comply with the new Regulatory Change requirements within thirty (30) days of the effective date of the Regulatory Change, unless otherwise instructed by DHCS. Notwithstanding a Regulatory Change, any amendment of a term to this Agreement must be in writing and executed by the Parties unless otherwise permitted or required by Laws.

9.4 Force Majeure. Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

9.5 Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California, federal laws and regulations applicable to the Programs, and all contractual obligations of CalOptima. Subject to the restrictions in Section 9.13, Provider shall bring any and all legal proceedings against CalOptima under this Contract in California State courts in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceedings shall be brought in the Central District Court of California.

9.6 Independent Contractor Relationship. Provider and any agents or employees of Provider in performance of this Contract shall act in an independent capacity and not as officers, employees, or agents of CalOptima. Provider's relationship with CalOptima in the performance of this Contract is that of an independent contractor. Provider's personnel performing services under this Contract shall be at all times under Provider's exclusive direction and control and shall be employees and/or agents of Provider, and CalOptima. Provider shall pay all wages, salaries, and other amounts due its employees in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, 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. Any failure of a Party to insist upon strict compliance with any provision of this Contract shall not be deemed a waiver of such provision or any other provision of this Contract. To be effective, a waiver must be in writing and signed and dated by the Parties..

9.9 Notices. Any notice required under this Contract, unless otherwise indicated herein, shall be in writing and sent by certified or registered mail, return receipt requested, postage prepaid to the address set out below. Notice shall be deemed given seventy-two (72) hours after mailing.

If to CalOptima:

CalOptima
Director of Contracting
505 City Parkway West
Orange, CA 92868

If to Provider:

{{*Name on Notice_es_:signer1: }}
Name
{{*Title on Notice_es_:signer1: }}
Title
{{*Address on Notice_es_:signer1 }}
Address

9.10 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 personal interest, direct or indirect, in this Contract or the proceeds thereof.

9.11 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.

9.12 Severability. If any provision of this Contract is rendered invalid or unenforceable by Laws or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect as though the invalid or unenforceable parts had not been included herein.

9.13 Dispute Resolution.

9.13.1 Meet and Confer. For any dispute not subject to or resolved by the provider appeals process, the Parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 9.13.2.

9.13.2 Arbitration. If the Parties are unable to resolve any dispute arising out of or relating to this Contract under Section 9.13.1, either party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties cannot agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

9.13.3 Exclusive Remedy. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 9.13.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the provider appeals or meet-and-confer processes.

9.13.4 Waiver. By agreeing to binding arbitration as set forth in Section 9.13.2, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

9.14 Interpretation. Each Party has had the opportunity to have counsel of its choice examine the provisions of this Contract, and no implication shall be drawn against any Party by virtue of the drafting of this Contract.

9.15 Without Limitation. The words "include", "includes", and "including" are not words of limitation and shall be deemed to be followed by the phrase "without limitation".

9.16 Recitals and Exhibits. The recitals, attachments, exhibits, and/or addenda set forth in this Contract are made a part of the Contract by this reference.

ARTICLE 10
EXECUTION

10.1 This Contract may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall be deemed one and the same instrument. Subject to the State of California and United States providing funding during the Term and for the purposes with respect to which it is entered into, execution of the Government Contracts, and the approval of the Contract by Regulators, this Contract shall become effective as of the Effective Date.

IN WITNESS WHEREOF, the Parties have executed this Contract as follows:

Provider	**CalOptima**
{{_es_:signer1:signature}}	{{_es_:signer2:signature}}
Signature	Signature
{{*Name_es_:signer1 }}	{{N_es_:signer2:fullname }}
Print Name	Print Name
{{*_es_:signer1:title }}	{{*_es_:signer2:title }}
Title	Title
{{*_es_:signer1:date }}	{{*_es_:signer2:date }}
Date	Date

Back to Agenda Back to Item

ATTACHMENT A
COVERED SERVICES

ARTICLE 1
SERVICES

1.1. Definitions. As used in this Attachment A, the capitalized words or phrases not otherwise defined in this Contract shall have the meanings set forth as follows:

1.1.1 "**Doula Services**" means services that encompass health education; advocacy; and physical, emotional, and nonmedical support provided before, during, and after childbirth or the end of a pregnancy, including throughout the Postpartum Period. Doula Services include support during miscarriage, stillbirth, and abortion. Doula Services also include health navigation; lactation support; development of a birth plan; and linkages to community-based resources.

1.1.2 "**Prenatal**" means the period of time during pregnancy and before birth.

1.1.3 **Postpartum Period**" means the period for up to 12 months from the end of pregnancy.

1.1.4 "**Recommendation**" means a recommendation for Doula Services from a physician or other licensed practitioner of the healing arts acting within their scope of practice under State law.

1.2. Covered Services and Limitations.

1.2.1. Covered Services. Covered Services under this Contract are limited to Doula Services. Provider shall furnish Covered Services to eligible Members in the Program who are referred to Provider in accordance with CalOptima Policies. Provider may provide Covered Services virtually or in-person with locations in any setting, including homes, office visits, hospitals, or alternative birth centers. Provider is not prohibited from teaching classes that are available at no cost to Members. Covered Services, when properly Authorized, consist of the following:

1.2.1.1. One initial Member visit.

1.2.1.2. Up to eight (8) additional visits that can be provided in any combination of Prenatal and Postpartum Period visits.

1.2.1.3. Support during labor and delivery, including labor and delivery resulting in a stillbirth, abortion, or miscarriage.

1.2.1.4. Up to two (2) extended, three (3)-hour Postpartum Period visits after the end of a Member's pregnancy.

1.2.2. Assistive and Supportive Services. Additional Covered Services include Provider providing assistive or supportive services to Members in their homes during a prenatal or Postpartum Period visit (i.e., Provider may help the Member fold laundry while providing emotional support and offering advice on infant care).

1.2.2.1. Assisted or supportive services provided in the home must be face-to-face and incidental to Covered Services provided during the prenatal or Postpartum Period visit.

1.2.2.2. Provider shall not bill Member for providing assistive or supportive services.

1.2.3. Limitations. All visits are limited to one per day per Member. Only one Doula can bill for a visit provided to the same Member on the same day, excluding labor and delivery. Provider can provide one prenatal visit or one Postpartum Period visit on the same day as labor and delivery, stillbirth, abortion, or miscarriage support. The prenatal or Postpartum Period visit billed on the same calendar day as birth can be billed by a different Doula.

1.2.4. Extended Visits. The extended three (3)-hour postpartum visits provided after the end of pregnancy do not require the Member to meet additional criteria or receive a separate Recommendation. Provider shall bill the extended Postpartum Period visits in fifteen (15)-minute increments, up to three (3) hours per visit, up to two (2) visits per pregnancy on separate days for each eligible Member.

1.2.5. Utilization Management. The provision of any Covered Service is subject to CalOptima's UM program and whether the service is Medical Necessary. Provider shall provide any assessment and evaluation services ordered by a court or legal mandate. Disputes regarding the Medical Necessity of any service can be appealed pursuant to CalOptima Policies.

1.3. Additional Visits. Provider must obtain a second Recommendation for additional visits beyond those provided in Section 1.2.4 during the Postpartum Period. Provider shall not use a standing order for a Recommendation for additional visits during the Postpartum Period. Any additional Recommendation from CalOptima will Authorize nine (9) or fewer additional Postpartum Period visits, as provided in the Authorization.

1.4. Training. Provider shall complete all necessary initial and ongoing training, including any available services for prenatal, perinatal, and Postpartum Period Members, provided or required by CalOptima.

1.5. Eligibility. Provider shall verify the Member's eligibility for the month in which Provider is to provide Covered Services. CalOptima agrees to grant Provider access to CalOptima's Member management information systems and make its customer service staff available so that Provider can verify each Member's eligibility to receive Covered Services on the date of service.

1.6. Referrals. Provider shall work with Members' PCPs and/or CalOptima to refer a Member to a Participating Provider if the Member requests or requires pregnancy-related services or any other services that are available under the Program. This shall include referrals for the following services:

1.6.1. Behavioral health services

1.6.2. Belly binding after cesarean section by clinical personnel

1.6.3. Clinical case coordination

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

1.6.5. Childbirth education group classes

1.6.6. Comprehensive health education, including orientation, assessment, and planning (comprehensive perinatal services program)

1.6.7. Hypnotherapy (non-specialty mental health service)

1.6.8. Lactation consulting, group classes, and supplies

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

1.6.10. Transportation

1.6.11. Medically appropriate community supports services under Medi-Cal

1.7. Non-Covered Services. The following services for pregnant or Postpartum Period Members are ***not*** Medi-Cal Doula services and are ***not*** Covered Services under this Contract:

1.7.1. Belly binding (traditional/ceremonial)

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

1.7.3. Group classes on babywearing

1.7.4. Massage (maternal or infant)

1.7.5. Photography

1.7.6. Shopping

1.7.7. Vaginal steams

1.7.8. Yoga

1.7.9. Diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure.

CalOptima will not reimburse Provider for any of the services in this Section 1.7. Provider may not bill any Members for services in this Section 1.7 unless Provider has first advised Member of their payment responsibility and obtained a written waiver from Member prior to rendering the non-Covered Services to the Member. The waiver must clearly specify all non-Covered Services that Provider will provide and state that the Member is responsible for payment of all of those services.

1.8. Documentation Requirements. Covered Services require a prior written Recommendation. Provider must document the date, time, and duration of Covered Services provided to Members. Documentation must also indicate the service provided and the length of time spent with the Member that day. Documentation should be integrated into the Member's medical record, available for encounter data reporting, and include Provider's National Provider Identifier (NPI) number. Provider shall furnish such required documentation to DHCS and CalOptima upon request. CalOptima will not reimburse Provider for Covered Services if Provider has not furnished adequate documentation, as required by this Contract and Laws, for services provided under this Contract.

1.9. Billing Codes. Provider must bill CalOptima with category of service 134 for Covered Services. Provider Claims for Covered Services do not require a diagnosis code. Provider may use the following CPT codes may be used for all Covered Services when submitting Claims to CalOptima:

1.9.1. Prenatal and Postpartum Visits.

1.9.1.1. Z1032 – Extended initial visit 90 minutes

1.9.1.2. Z1034 – Prenatal visit

1.9.1.3. Z1038 – Postpartum visit

1.9.1.4. HCPCS T1032 – Extended postpartum support, per 15 minutes

1.9.2. Labor and Delivery Support

1.9.2.1. CPT 59409 –Doula support during vaginal delivery only

1.9.2.2. CPT 59612 – Doula support during vaginal delivery after previous caesarian section

1.9.2.3. CPT 59620 – Doula support during caesarian section

1.9.3. Abortion and Miscarriage Support

1.9.3.1. HCPCS T1033 – Doula support during or after miscarriage

1.9.3.2. CPT 59840 – Doula support during or after abortion

1.9.4. Billing codes for support during labor and delivery are limited to once per Member pregnancy. Support during labor and delivery can be billed if theses service are provided by a Doula, whether or not the delivery results in a live birth.

1.9.5. Billing codes HCPCS code T1033 for miscarriage support and CPT code 59840 for abortion support are each limited to once per Member pregnancy.

ARTICLE 2
GENERAL PROVIDER RESPONSIBILITIES

2.1 Days to Appointment. Provider shall ensure that appointments for Covered Services are scheduled within fifteen (15) business days of a Member's request. Provider shall also have a process in place for follow-up and reschedule of Member missed appointments.

2.2 Office Waiting Times. Doula shall ensure that office wait times will be kept to a maximum of forty-five (45) minutes.

2.3 Health Education and Prevention. Provider shall provide Members with health education during office visits in accordance with CalOptima Policies. Provider shall also refer Members to CalOptima's health education referral line for classes provided to Members.

2.4 Coordination of Care. Provider shall coordinate the provision of Covered Services to Members by counseling Members and their families regarding Member's needs, monitoring progress of

Members' care, and coordinating utilization of services with Member's PCP.

2.5 Treatment Options. Provider shall discuss treatment options with Members, including the option of foregoing treatment, in a culturally competent manner. Provider shall ensure that Members with disabilities have access to effective communication methods when making care decisions and shall allow Members the opportunity to refuse treatment and express preferences for future treatment.

2.6 Doula shall also provide services to COD-Administrative Members under this Contract. The scope of such services shall be defined in CalOptima Policies, as well as Article 2 of this Attachment A. In the event of a conflict between CalOptima Policies and this Article 2, CalOptima Policies shall control with respect to COD-Administrative Members.

2.7 Doula shall comply with CalOptima's model of care, as specified for the Program.

2.8 Personal Care Coordinator. Provider shall cooperate with CalOptima's personal care coordinator ("**PCC**") in accordance with CalOptima's PCC program, policies, and guidance.

2.9 Interdisciplinary Care. Provider shall participate with CalOptima's Interdisciplinary Care Team and contribute to the Individualized Care Plan for each Member in accordance with CalOptima Policies and Program.

ATTACHMENT B
PROCEDURES FOR REQUESTING INTERPRETATION SERVICES

ARTICLE 1
CALOPTIMA DIRECT MEMBERS

1.1 CalOptima Responsibilities. CalOptima shall provide Members enrolled in 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 interpretation services for a Member, Provider shall, at least one week before the scheduled appointment with the Member, contact CalOptima Customer Service Department at (714) 246-8500 to be connected with the Cultural and Linguistic ("**C&L**") Coordinator. CalOptima requires the following information at the time of the request:

1.2.1 Member name and ID, date of birth, and telephone number;

1.2.2 Name and phone number of the caretaker, if applicable;

1.2.3 Language or sign language needed;

1.2.4 Date and time of the appointment;

1.2.5 Address and telephone number of the facility where the appointment is to take place;

1.2.6 Estimated amount of time the interpretation service will be needed; and

1.2.7 Type of appointment: assessment, fitting/delivery, or other.

1.3 Provider's Responsibilities.

1.3.1 C&L Coordinator. CalOptima C&L Coordinator will make best efforts to secure an interpreter within seventy two (72) hours of a request and will confirm the results of this effort to the Provider and Member.

1.3.2 Appointment Changes. If there is any change with the appointment, Provider shall contact C&L Coordinator at least seventy two (72) hours before the scheduled appointment.

1.3.3 Provider Obligation for Cost. If Provider fails to communicate with C&L Coordinator an interpretation request or change to an interpretation request more than seventy two (72) hours before the appointment, Provider will incur the cost of an urgent interpretation service request.

ARTICLE 2
HEALTH NETWORK MEMBERS

2.1 Health Network Contact. For Health Network Members, Provider shall contact Member's Health Network customer service department to request the needed interpretation services and shall follow the Health Network policy and procedures for those services.

ATTACHMENT C
COMPENSATION

Upon submission of a Clean Claim, CalOptima shall pay Provider pursuant to CalOptima Policies and Laws, and Provider shall accept as payment in full from CalOptima for services provided under this Contract the following amounts:

1. Covered Services. For Covered Services provided to Members, or as otherwise noted below, CalOptima shall reimburse Provider the lesser of:

   1.1 Provider's full billed charges.

   1.2 100% of amount listed for the service in the applicable CalOptima Medi-Cal fee schedule in effect as of the date of service, as defined in CalOptima Policies.

   If a Health Network is financially responsible under its contract with CalOptima for the services a Provider rendered to a Member, Provider shall look solely to Health Network for payment for those services, and CalOptima and Member shall not be liable to Provider for those services.

2. Services with Unestablished Fees. If a fee has not been established by Medi-Cal for a particular procedure and CalOptima has provided Authorization for Provider to provide such service, CalOptima shall reimburse Provider under the following guidelines:

   2.1 "By Report & Unlisted" codes that CalOptima has provided Authorization for Provider to provide such services will be paid at [Percent] of Provider's full billed charges and must follow Medi-Cal billing rules and guidelines. When billing CalOptima for these codes, Provider shall include documentation of Covered Services provided, as required by this Contract, CalOptima Policies, and Laws.

3. Payment Procedures.

   3.1 Provider shall utilize current payment codes and modifiers for Med-Cal when billing CalOptima.

   3.2 CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

   3.3 If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Provider for additional justification and these will be handled on a case-by-case basis.

   3.4 Billing and Claims Submission. Provider shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

   3.5 Prompt Payment. CalOptima shall make payments to Provider in the time and manner set forth in CalOptima Policies and Laws.

   3.6 Claims Deficiencies. CalOptima shall deny payment for any Claim that fails to meet requirements set forth in CalOptima Policies and Laws for Claims processing, and CalOptima shall notify Provider of any denial pursuant to CalOptima Policies and Laws.

Back to Agenda Back to Item

ATTACHMENT D
Regulatory Requirements

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima's Medi-Cal Program. If there is a conflict between any terms in this Attachment D and those in the rest of the Contract, the terms in this Attachment D shall prevail.

1. Records Retention. Provider and Subcontractors 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 ("**DHCS Contract**"), or from the date of completion of any audit, whichever is later. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's books and records shall be maintained within, or be otherwise accessible within the State and pursuant to Health & Safety Code § 1381(b). Such records shall be maintained and retained on Provider's and Subcontractor's respective premises for such period as may be required by Laws 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 agency 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.

2. Access to Books and Records. Provider agrees, and shall ensure its Subcontractors agree in Subcontracts, to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining 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 the Access Requirements and State's Right to Monitor, as set forth in the: (a) by CalOptima, Regulators, the Department of Justice ("**DOJ**"), Bureau of Medi-Cal Fraud, Comptroller General, and any other entity statutorily entitled to have oversight responsibilities over CalOptima and/or Provider and its Subcontractors, (b) at all reasonable times at Provider's and Subcontractor's respective places of business or at such other mutually agreeable location in the State, and (c) in a form maintained in accordance with the general standards applicable to such book or record keeping. Provider and Subcontractors shall provide access to all security areas and facilities and cooperate and assist State representatives in the performance of their duties. If DHCS, CMS, or the HHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the HHS Inspector General may inspect, evaluate, and audit Provider or Subcontractors 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 Provider or any Subcontractor; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract due to fraud.

   Provider and Subcontractors shall cooperate in the audit process by signing any consent forms or documents required by but not limited to: DHCS, DMHC, the DOJ, Attorney General, Federal Bureau of Investigation, Bureau of Medi-Cal Fraud, and/or CalOptima to release any records or documentation Provider may possess in order to verify Provider's records.

   This provision shall survive the expiration or termination of this Contract and Subcontractors. [DHCS Contract, Exhibit E, Attachment 2, Provision 20]

3. 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 Welfare and Institutions Code Article 3.5 (commencing with Section 14124.70), Part 3, Division 9.

4. Records Related to Recovery for Litigation.

4.1 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 requests shall include a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such requests. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records received by Provider or its Subcontractors related to this Contract or Subcontracts. Provider further agrees to timely gather, preserve, and provide to DHCS any records in Provider's or its Subcontractor's possession. [DHCS Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision]

4.2 CalOptima agrees to pay Provider for complying with Section 4.1 as follows:

4.2.1 CalOptima shall reimburse Provider amounts paid by Provider to third parties for services necessary to comply with Section 4.1. Any third party assisting Provider with compliance with Section 4.1 shall comply with all applicable confidentiality requirements. Amounts paid by Provider to any third party for assisting Provider in complying with Section 4.1, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by CalOptima.

4.2.2 If Provider uses existing personnel and resources to comply with Section 4.1, 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.

4.2.2.1 Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to Section 4.1.

4.2.2.2 Costs for copies of all documentation submitted to CalOptima pursuant to Section 4.1, subject to a maximum reimbursement of ten (10) cents per copied page.

4.2.2.3 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.

5. Medical Records. All medical records shall meet the requirements of 28 CCR § 1300.80(b)(4) and 42 USC § 1936a(w). Such records shall be available to health care providers at each encounter, in accordance with 28 CCR § 1300.67.1(c). Provider shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Subcontractor site.

6. Downstream Contracts. If Provider is allowed to subcontract services under this Contract and does so subcontract, then Provider shall, upon request, provide copies of such Subcontracts to CalOptima and/or DHCS.

7. Medi-Cal Policies. Covered Services provided under this Contract shall comply with all applicable Medi-Cal Managed Care Division Policy Letters.

8. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least seventy five (75) days prior to the proposed effective date. DHCS's denial of the proposal shall prohibit implementation of the proposed changes.

9. Confidentiality of Medi-Cal Members.

   9.1 In accordance with 42 CFR § 431.300 *et seq*., as well as Welfare & Institutions Code § Section 14100.2 and regulations adopted thereunder, Provider and its employees, agents, and Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Provider, its employees, and/or agents as a result of services performed under this Contract, except for statistical information not identifying any such persons. Provider and its employees, agents, and Subcontractors shall not use or disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima.

   9.2 Provider and its employees, agents, and Subcontractors shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider may release medical records in accordance with Laws pertaining to the release of this type of information. Provider is not required to report requests for medical records made in accordance with Laws.

   9.3 With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider or its Subcontractors, Provider will, at the termination or expiration of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Provider by CalOptima for this purpose

   9.4 For purposes of this Section 9, identity shall include the name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

10. Debarment Certification. By signing this Contract, Provider agrees to comply with applicable federal suspension and debarment regulations, including 7 CFR Part 3017, 45 CFR Part 76, 40 CFR Part 32, and 34 CFR Part 85.

    10.1 By signing this Contract, the Provider certifies to the best of its knowledge and belief, that it and its principals:

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

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

10.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of the offenses enumerated in Section 11.1.2 above;

10.1.4 Have not within a three (3)-year period preceding the Effective Date had one or more public transactions (federal, state, or local) terminated for cause or default;

10.1.5 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 Part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

10.1.6 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.

10.2 If the Provider is unable to certify to any of the statements in this Section 11, Provider shall submit an explanation to CalOptima prior to the Effective Date and then immediately upon any change in the certifications above during the Term.

10.3 The terms and definitions in this Section 11 not otherwise defined in the Contract have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

10.4 If the Provider knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause.

11. DHCS Directions. If required by DHCS, Provider and its Subcontractors shall cease specified services for Members, which may include referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

12. Lobbying Restrictions and Disclosure Certification.

12.1 This Section 13 is applicable to federally funded contracts in excess of $100,000 per 31 USC § 1352. If this Section 13 is applicable to the Contract, Provider shall comply with the requirements in this Section 13, as well as complete the disclosure forms in Attachment F prior to the Effective Date.

12.2 Certification and Disclosure Requirements.

12.2.1 If this Contract is subject to 31 USC § 1352 and exceeds $100,000 at any tier, Provider shall file the certification and disclosure forms in Attachment F prior to the Effective Date .

12.2.2 Provider shall file a disclosure (in the form set forth in Attachment F, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if Provider 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 that would be prohibited under Section 12.3 if paid for with appropriated funds.

12.2.3 Provider shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by Provider under Section 12.2.2. An event that materially affects the accuracy of the information reported includes:

12.2.3.1 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;

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

12.2.3.3 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.

12.2.4 Each Subcontractor who requests or receives from Provider or Subcontractor a contract, subcontract, grant, or subgrant exceeding $100,000 at any tier under this Contract shall file a certification, and a disclosure form, if required, to the next tier above that Subcontractor.

12.2.5 All disclosure forms (but not certifications) completed under this Section 13.2 and Attachment F shall be forwarded from tier to tier until received by CalOptima. CalOptima shall forward all disclosure forms to DHCS program contract manager.

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

13. Additional Subcontracting Requirements.

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13.1 Provider shall require all Subcontracts that relate to the provision of Medi-Cal Covered Services to Members be in writing and include the following:

13.1.1 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.

13.1.2 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.

13.1.3 An agreement that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 9.1 of the base Contract.

13.1.4 An agreement to submit provider data, Encounter Data, and reports related to the Subcontract in accordance with Section 2.22 of the Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Section 5 of this Attachment F.

13.1.5 An agreement to hold harmless the State, Members, and CalOptima if 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 4.6 of the base Contract.

13.1.6 An agreement to notify DHCS in the manner if the Subcontract is amended or terminated.

13.1.7 An agreement to the provision of interpreter services to Members at all provider sites as set forth in Section 2.16 of the base Contract and to comply with the language assistance standards developed pursuant to Health & Safety Code § 1367.04.

13.1.8 Subcontractors shall have access to CalOptima's provider appeals mechanism in accordance with Section 8.1 of the base Contract.

13.1.9 An agreement to participate and cooperate in quality improvement system as set forth in Section 2.12 of the base 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.

13.1.10 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Section 2.4 of the base Contract.

13.1.11 An agreement by 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 base Contract.

13.1.12 An agreement for the establishment and maintenance of and access to medical and administrative records as set forth in Sections 6.1 and 6.2 of the base Contract and Sections 1, 2 and 6 of this Attachment F.

13.1.13 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.

13.1.14 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 6.5.3 or the base 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.

14. State's Right to Monitor. Provider shall comply, and shall ensure its Subcontractors comply, with all monitoring provisions of this Contract, the DHCS Contract, and any monitoring requests by CalOptima and Regulators. Without limiting the foregoing, CalOptima and authorized State and federal agencies will have the right to monitor, inspect, or otherwise evaluate all aspects of the Provider's and Subcontractor's operations for compliance with the provisions of this Contract and Laws. Such monitoring, inspection, or evaluation activities will include inspection and auditing of

Provider, Subcontractor, and Provider's and Subcontractors' facilities, management systems and procedures, and books and records, at any time, pursuant to 42 CFR § 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Provider. Access will be undertaken in such a manner as to not unduly delay the work of the Provider and/or the Subcontractor(s).

15. Provider shall comply with language assistance standards developed pursuant to Health & Safety Code § 1367.04.

16. 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 Part 15.5. If applicable Provider agrees to comply with all standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 *et seq*.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 *et seq*.), as amended.

17. This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract between CalOptima and DHCS.

18. Provider agrees, and shall ensure its Subcontractors agree, to assist CalOptima in the transfer of care if the Contract or any Subcontract terminates for any reason.

19. Notwithstanding anything in this Contract to the contrary, Provider shall be entitled to the protections of the Health Care Providers' Bill of Rights in Health and Safety Code § 1375.7 in the administration of this Contract.

20. 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.

ATTACHMENT E

MEDI-CAL DISCLOSURE FORM

@@Provider Name@@
Name of Provider

The undersigned hereby certifies that the following information regarding **@@Provider Name@@** (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

{{*Owner1_es_:signer1	}}
{{Owner2_es_:signer1	}}
{{Owner3_es_:signer1	}}
{{Owner4_es_:signer1	}}

Co-Owner(s):

{{*Co-Owner1_es_:signer1	}}
{{Co-Owner2_es_:signer1	}}
{{Co-Owner3_es_:signer1	}}
{{Co-Owner4_es_:signer1	}}

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

{{*Ownership(%)1_es_:signer1	}}
{{Ownership(%)2_es_:signer1	}}
{{Ownership(%)3_es_:signer1	}}
{{Ownership(%)4_es_:signer1	}}

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

{{*Creditor(%)1_es_:signer1	}}
{{Creditor(%)2_es_:signer1	}}
{{Creditor(%)3_es_:signer1	}}
{{Creditor(%)4_es_:signer1	}}

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

{{*Company Type1_es_:signer1	}}
{{Company Type2_es_:signer1	}}
{{Company Type3_es_:signer1	}}
{{Company Type4_es_:signer1	}}

Date: {{_es_:signer1:date }}

Signature: {{_es_:signer1:signature }}

Name: {{Name_es_:signer1: }}
(Please type or print)

Title: {{_es_:signer1:title }}
(Please type or print)

Back to Agenda Back to Item

ATTACHMENT F
LOBBYING CERTIFICATION FORMS

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including Subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

@@Provider Name@@ Name of Contractor	{{Name_es_:signer1: }} Printed Name of Person Signing for Contractor
{{_es_:signer1:signature}} Contract / Grant Number	Signature of Person Signing for Contractor
{{_es_:signer1:date }} Date	{{_es_:signer1:title }} Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

@@Custom Field{Lobby Check Box}@@

CERTIFICATION REGARDING LOBBYING

Approved by OMB

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

0348-0046

1. Type of Federal Action: {{[]}} contract {{[]}} grant {{[]}} cooperative agreement {{[]}} loan {{[]}} loan guarantee {{[]}} loan insurance	2. Status of Federal Action: {{[]}} bid/offer/application {{[]}} initial award {{[]}} post-award	3. Report Type: initial {{[]}} initial filing {{[]}} material change For Material Change Only: Year {{Yr_es_signer1}} quarter {{Qtr_es_signer1}} date of last report

4. Name and Address of Reporting Entity: {{RepEntNm_es_signer1 }} Prime Subawardee Tier, if known: {{Tier_es_signer1 }}	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: {{RepEntNm_es_signer1 }}
Congressional District, If known: {{CongDist_es_signer1 }}	Congressional District, If known: {{CongDist _es_signer1 }}
6. Federal Department/Agency: {{FedDept_es_signer1 }}	7. Federal Program Name/Description: {{FedProg_es_signer1 }} CDFA Number, if applicable: {{CDFA _es_signer1 }}
8. Federal Action Number, if known: {{FedDept_es_signer1 }}	9. Award Amount, if known: {{AwardAmt_es_signer1 }}
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): {{LobEntNm_es_signer1 }} {{LobEntAd_es_signer1 }} (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): {{LobEntNm2_es_signer1}} SF-LLL-A, If necessary)
Amount of Payment (check all that apply): ${{Amt_es_signer1}} actual planned	13. Type of Payment (Check all that apply): {{[]}} a. retainer {{[]}} b. one-time fee {{[]}} c. commission {{[]}} d. contingent fee {{[]}} e deferred {{[]}} f. other, specify: {{Other_es_signer1}}
Form of Payment (check all that apply): a. {{[]}} cash b. {{[]}} in-kind, specify: Nature	
Value {{Value_es_:signer1 }}	

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:
{{SrvcPerf_es_:signer1:multiline(4) }}

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes {{[]}} No {{[]}}

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the	Signature: {{_es_:signer1:signature:showif(lobby=Checked)}} Print Name: {{Name_es_:signer1:showif(lobby=Checked)}} Title: {{_es_:signer1:title:showif(lobby=Checked)}}

Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Telephone No.: {{Mobile_es_:signer1:phone:showif(lobby=Checked)}} Date: : {{_es_:signer1:date:showif(lobby=Checked)}}
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

{{lobby_es_:checkbox:signer1}}

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503

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

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: December 27, 2022

ALL PLAN LETTER 22-031

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: DOULA SERVICES

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with guidance regarding the qualifications for providing doula services, effective for dates of service on or after January 1, 2023.

BACKGROUND:
Per State Plan Amendment (SPA) 22-0002, doula services are provided as preventive services pursuant to Title 42 Code of Federal Regulations (CFR) Section 440.130(c) and must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law.[1,2] Doulas provide person-centered, culturally competent care that supports the racial, ethnic, linguistic, and cultural diversity of Members while adhering to evidence-based best practices. Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.

Doulas are birth workers who provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion. Doulas are not licensed and they do not require supervision.

Doulas also offer various types of support, including health navigation; lactation support; development of a birth plan; and linkages to community-based resources.

[1] The CFR is searchable available at: https://www.ecfr.gov/
[2] SPA information is available at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx

POLICY:

Covered Doula Services
Effective January 1, 2023, MCPs are required to provide doula services for prenatal, perinatal and postpartum Members. Doula services can be provided virtually or in-person with locations in any setting including, but not limited to, homes, office visits, hospitals, or alternative birth centers.[3]

An initial recommendation for doula services includes the following authorizations:

- One initial visit.
- Up to eight additional visits that can be provided in any combination of prenatal and postpartum visits.
- Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion, or miscarriage.
- Up to two extended three-hour postpartum visits after the end of a pregnancy.

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

The extended three-hour postpartum visits provided after the end of pregnancy do not require the Member to meet additional criteria or receive a separate recommendation. The extended postpartum visits are billed in 15-minute increments, up to three hours, up to two visits per pregnancy per individual provided on separate days.

If a Member requests or requires pregnancy-related services that are available through Medi-Cal, then the doula should work with the Member's Primary Care Provider (if that information is available) or work with the MCP to refer the Member to a Network Provider who is able to render the service.[4] These Medi-Cal services include but are not limited to:

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[3] Doulas should refer to the Telehealth section in Part 2 of the Provider Manual for guidance regarding providing services via telehealth for prenatal or postpartum visits, labor and delivery support, and for abortion and miscarriage support. The Medi-Cal Provider Manual, Medicine: Telehealth, is available at: https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf

[4] If the service is included in the benefits offered through the MCP, the Provider must be in-network unless the Provider type is unavailable. If the Provider type is unavailable, the MCP

- Behavioral health services
- Belly binding after cesarean section by clinical personnel
- Clinical case coordination
- Health care services related to pregnancy, birth, and the postpartum period
- Childbirth education group classes
- Comprehensive health education including orientation, assessment, and planning (Comprehensive Perinatal Services Program services)
- Hypnotherapy (non-specialty mental health service)
- Lactation consulting, group classes, and supplies
- Nutrition services (assessment, counseling, and development of care plan)
- Transportation
- Medically appropriate Community Supports services[5]

A doula is not prohibited from providing assistive or supportive services in the home during a prenatal or postpartum visit (i.e., a doula may help the postpartum person fold laundry while providing emotional support and offering advice on infant care). The visit must be face-to-face, and the assistive or supportive service must be incidental to doula services provided during the prenatal or postpartum visit. The Member cannot be billed for the assistive or supportive service.

Additionally, MCPs must provide doulas with all necessary, initial and ongoing training and resources regarding relevant MCP services and processes, including any available services through the MCP for prenatal, perinatal, and postpartum Members. This training must be provided initially when doulas are enrolled with the MCPs, as well as on an ongoing basis. Further, MCPs are required to provide technical support in the administration of doula services, ensuring accountability for all service requirements contained in the Contract, and any associated guidance issued by the Department of Health Care Services (DHCS).

Member Eligibility Criteria for Doula Services
To be eligible for doula services, and be covered under Medi-Cal managed care, a beneficiary must be eligible for Medi-Cal, enrolled in the MCP, and have a

---

must arrange for out-of-network services. If the service referral is for a benefit that is not included in those offered through the MCP, the MCP must coordinate a warm hand off with the entity responsible for the carved-out service.

[5] A list of Community Supports by Medi-Cal Managed Care plans can be found here: https://www.dhcs.ca.gov/Documents/MCQMD/Community-Supports-Elections-by-MCP-and-County.pdf and information regarding Community Supports can be found here: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf.

recommendation for doula services from a physician or other licensed practitioner of the healing arts.

- **Medi-Cal Eligibility Checks**: Doulas must verify the Member's Medi-Cal eligibility for the month of service. Doulas must contact the Member's assigned MCP to verify eligibility.

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

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

The following services are not covered under Medi-Cal or as doula services:

- Belly binding (traditional/ceremonial)
- Birthing ceremonies (i.e., sealing, closing the bones, etc.)
- Group classes on babywearing
- Massage (maternal or infant)
- Photography
- Placenta encapsulation
- Shopping
- Vaginal steams
- Yoga

Doulas are not prohibited from teaching classes that are available at no cost to Members to whom they are providing doula services.

Documentation Requirements
Doula services require a written recommendation by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law. The recommending physician or licensed practitioner does not need to be enrolled in Medi-Cal or be a Network Provider within the Member's MCP.

The initial recommendation can be provided through the following methods:

- Written recommendation in Member's record.
- Standing order for doula services by MCP, physician group, or other group by a licensed Provider.
- Standard form signed by a physician or other licensed practitioner that a Member can provide to the doula.

A second recommendation is required for additional visits during the postpartum period. A recommendation for additional visits during the postpartum period cannot be established by standing order. The additional recommendation authorizes nine or fewer additional postpartum visits.

MCPs must ensure doulas document the dates, time, and duration of services provided to Members. Documentation must also reflect information on the service provided and the length of time spent with the Member that day. For example, documentation might state, "Discussed childbirth education with the Member and discussed and developed a birth plan for one hour." Documentation should be integrated into the Member's medical record and available for encounter data reporting. The doula's National Provider Identifier (NPI) number should be included in the documentation. Documentation must be accessible to the MCP and DHCS upon request.

Doula Provider Requirements and Qualifications
All doulas must be at least 18 years old, possess an adult/infant Cardiopulmonary Resuscitation (i.e., CPR) certification, and have completed Health Insurance Portability and Accountability Act training. Additionally, a doula must qualify by meeting either the training or experience pathway, as described below:

<u>Training Pathway:</u>

- Complete a minimum of 16 hours of training in the following areas:
  - Lactation support
  - Childbirth education
  - Foundations on anatomy of pregnancy and childbirth
  - Nonmedical comfort measures, prenatal support, and labor support techniques
  - Developing a community resource list
- Provide support at a minimum of three births

Experience Pathway:

- All of the following:
  - At least five years of active doula experience in either a paid or volunteer capacity within the previous seven years.
  - Attestation to skills in prenatal, labor, and postpartum care as demonstrated by the following: Three written client testimonial letters, or professional letters of recommendation from any of the following: a physician, licensed behavioral health provider, nurse practitioner, nurse midwife, licensed midwife, enrolled doula, or community-based organization. Letters must be written within the last seven years. One letter must be from either a licensed Provider, a community-based organization, or an enrolled doula. "Enrolled doula" means a doula enrolled either through DHCS or through a MCP.

Continuing Education:
MCPs must ensure doulas complete three hours of continuing education in maternal, perinatal, and/or infant care every three years. Doulas must maintain evidence of completed training to be made available to DHCS upon request.

Provider Enrollment
Network Providers, including those who will operate as Providers of doula services, are required to enroll as Medi-Cal Providers, consistent with APL 22-013, or any superseding APL, if there is a state-level enrollment pathway for them to do so.[6]

Billing, Claims, and Payments
MCPs must reimburse doulas in accordance with their Network Provider contract. MCPs are prohibited from establishing unreasonable or arbitrary barriers for accessing doula services. Claims for doula services must be submitted with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual.[7] Doulas cannot double bill, as applicable, for doula services that are duplicative to services that are reimbursed through other benefits.

Access Requirements for Doula Services
As part of their Network composition, MCPs must ensure and monitor sufficient Provider Networks within their service areas, including doulas. To support an adequate doula Network, MCPs must make contracting available to both individual doulas and doula groups. MCPs must work with their network hospitals/birthing centers to ensure there

[6] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
[7] The Medi-Cal Provider Manual, Doula Services, is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/doula.pdf

are no barriers to accessing these Providers when accompanying Members for prenatal visits, labor and delivery support, and postpartum visits regardless of outcome (stillbirth, abortion, miscarriage, live birth).

DHCS Monitoring
DHCS will monitor MCPs' initial implementation of doula services and requirements through existing data reporting mechanisms such as Encounter Data, Grievances and Appeals, and the 274 Network Provider File. MCPs must ensure that doula services Providers have NPIs and that these NPIs are entered in the 274 Network Provider File.

The requirements contained in this APL will necessitate a change in an MCPs' contractually required policies and procedures (P&Ps), MCPs must submit their updated P&Ps to their Managed Care Operations Division (MCOD) contract manager within 90 days of the release of this APL.

MCPs are responsible for ensuring their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters.[8] These requirements must be communicated by each MCP to all its Subcontractors and Network Providers.

If you have any questions regarding the requirements of this APL, please contact your MCOD contract manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

[8] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, "Medi-Cal Managed Care Health Plan Guidance on Network Provider Status," or any superseding APL on this topic.

Policy:	GG.1707
Title:	**Doula Services**
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	*/s/ Michael Hunn 06/01/2023*
Effective Date:	01/01/2023
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

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

II. POLICY

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

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

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

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

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

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

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

Back to Agenda Back to Item

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

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

III. PROCEDURE

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

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

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

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

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

C. Initial Recommendation

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

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

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

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

2. The initial recommendation includes the following authorizations:

a. One initial visit;

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

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

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

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

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

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

a. Behavioral health services;

b. Belly binding after cesarean section by clinical personnel;

c. Clinical case coordination;

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

e. Childbirth education group classes;

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

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

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

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

j. Transportation; and

k. Medically appropriate Community Supports services.

F. Eligibility Criteria for Doula Services

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

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

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

G. Documentation Requirements

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

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

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

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

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

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

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

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

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

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

H. Doula Requirements and Qualifications

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

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

   a. Training Pathway:

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

         a) Lactation support;

         b) Childbirth education;

         c) Foundations on anatomy of pregnancy and childbirth;

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

         e) Developing a community resource list.

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

b. Experience Pathway:

i. All of the following:

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

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

c. Continuing Education:

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

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

I. Non-Covered Doula Services:

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

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

a. Belly binding (traditional/ceremonial);

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

c. Group classes on babywearing;

d. Massage (maternal or infant);

e. Photography;

f. Placenta encapsulation;

g. Shopping;

h. Vaginal steams; and

i. Yoga.

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

J. Billing and Payments

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

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

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

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

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

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

K. Monitoring

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

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

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy AA.1270: Certification of Document and Data Submissions
B. CalOptima Health Policy EE.1103: Provider Network Training
C. CalOptima Health Policy EE.1111: Health Network Encounter Reporting Requirements
D. CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible
E. CalOptima Health Policy FF.1014: Payment for Covered Services Rendered to a Member Enrolled in a Health Network
F. CalOptima Health Policy GG.1600: Access and Availability Standards
G. CalOptima Health Policy GG.1603: Medical Records Maintenance
H. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners

Back to Agenda Back to Item

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

VI. REGULATORY AGENCY APPROVAL(S)

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

VII. BOARD ACTION(S)

Date	Meeting
06/01/2023	Regular Meeting of the CalOptima Heath Board of Directors

VIII. REVISION HISTORY

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

IX. GLOSSARY

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

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

18. Authorize Employee and Retiree Group Health Insurance and Wellness Benefits for Calendar Year 2024

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Brigette Hoey, Chief Human Resources Officer, Human Resources, (714) 246-8405

Recommended Actions

1. Authorize the Chief Executive Officer to enter into contracts and/or amendments to existing contracts, as necessary, to continue to provide group health insurance, including medical, dental, and vision, for CalOptima Health employees and eligible retirees (and their dependents); basic life, accidental death and dismemberment (ADD), short-term disability (STD) and long-term disability (LTD) insurance; an employee assistance program; and flexible spending accounts (FSA) for Calendar Year (CY) 2024 in an amount not to exceed $32.0 million, which includes the following recommended program updates with estimated cost changes:

    a. The renewal of the current Blue Shield of California Health Maintenance Organization (HMO) plans, Preferred Provider Organization (PPO) plan, PPO Savings High Deductible Health Plan (HDHP), Blue Shield of California Dental HMO and PPO plans, Kaiser Permanente (Kaiser) HMO, Kaiser Senior Advantage, AmWins Retiree Medicare Supplement Plan, VSP vision, New York Life Basic Life/ADD, STD, LTD, Aetna Resources for Living Employee Assistance Program (EAP), and Wex Flexible Spending Account (FSA) plans and COBRA administration with no changes in plan designs.

    b. An increase in employer contributions for active and retiree medical plans of 7.9% or $2,159,825 from CY 2023 due to an overall rise in premium rates. The total employer contribution for CY 2024 is $24,519,676. The total employee contribution will remain unchanged from CY 2023.

    c. An increase in employer contributions of 28.0% or $73,150 from CY 2023 to fund the Health Savings Accounts (HSA) for employees anticipated to enroll in the Blue Shield PPO Savings HDHP. The total employer contribution for CY 2024 is $334,400.

    d. The elimination of the spousal surcharge imposed on employees who cover a spouse who has access to alternative group health plans. The total net fiscal impact to CalOptima Health is $247,200 in CY 2024.

    e. The addition of $51,000 in funding to offer on-site and virtual counseling and mental health services through Aetna Resources for Living EAP.

2. Authorize the receipt and expenditures for CalOptima Health staff wellness programs of $75,000 in funding from Blue Shield of California for CY 2024.

Back to Agenda

Background

California Government Code section 53201 provides that local public agencies, including CalOptima Health, have the option of providing health and welfare benefits for their officers, employees, and retired employees who elect to accept the benefits and who authorize the local agencies to deduct the premiums, dues, or other charges from their compensation. Government Code section 53200 provides that health and welfare benefits may include hospital, medical, surgical, dental, disability, group life, legal expense, and income protection insurance or benefits. From April 2020 through March 2024, CalOptima Health will be purchasing insurance through Alliant Insurance Services (Alliant), an insurance broker. CalOptima Health currently contracts with both Kaiser and Blue Shield of California to provide group health insurance coverage for all benefited employees and qualifying retirees. CalOptima Health also contracts with AmWins to provide Medicare supplemental coverage for qualifying Medicare eligible retirees and their dependents.

By statute, the Board may authorize payment of all, or such portion as it may elect, of premiums for these health and welfare benefits. CalOptima Health currently pays a portion of the premiums for health and welfare benefits for employees and eligible retired employees, as well as their eligible dependents. A summary of employer and employee contributions since plan year 2020 is provided below.

- In plan year 2020, there was an 8.0% increase in premium rates in the amount of $1,605,723, and CalOptima Health and employees shared in the costs of premium rate increases.
- In plan year 2021, there was a 7.2% decrease in premium rates in the amount of $1,570,131. With rate caps for 2022 set as high as 12.0%, it was assumed the premium rates for CY 2022 would likely increase to such an extent that rates would essentially return to the same premium rates as 2020. As such, the contribution strategy adopted in 2020 was to hold employee contribution rates (no decrease or increase) steady for the two years when CalOptima Health would experience a decrease in premiums (plan year 2021) and then an increase in premiums (plan year 2022).
- As anticipated, in plan year 2022 there was an increase in premium rates of 7.3% or $1,590,567, and CalOptima Health absorbed this premium increase, with no increase to employee contribution rates.
- In an effort to mitigate premium increases in plan year 2023, CalOptima Health replaced the Cigna medical and dental plans with Blue Shield of California plans and absorbed the 9.3% rise in premium rates, or $2,185,777, with no increase to employee contribution rates.

Discussion

On behalf of CalOptima Health, Alliant negotiated for the renewal of CalOptima Health's health and welfare benefits for CY 2024, including a targeted marketing analysis for renewal options if CalOptima Health were to join the PRISMHealth risk sharing pool. However, these options either did not offer immediate or significant cost-savings to CalOptima Health, and/or they were not competitive with existing plans. As such, staff recommends renewing the current Kaiser and Blue Shield of California medical and dental plans, VSP vision, New York Life Basic Life/ADD, STD, LTD, Aetna Resources for Living EAP, and Wex FSA plans and COBRA administration in CY 2024, resulting in a gross increase of 7.9%, or $2,159,825 from CY 2023.

Back to Agenda

Based on the recommendations below, the total employer contributions for CY 2024 will result in an increase of approximately 9.2% or $2,531,175 from CY 2023. The proposed change in premiums is below the regional average, which is experiencing renewal increases ranging from 10.5% to 16.0%.

Cost of Benefits	**CY 2023**	**CY 2024**	**Difference (CY 2024 – CY 2023)**
Active and Retiree Medical Insurance (Blue Shield, Kaiser, AmWins)	$24,407,472	$26,567,297	$2,159,825
Wellness Activities	$75,000	$75,000	$0
Wellness Funding	($75,000)	($75,000)	$0
Dental Insurance	$1,489,923	$1,489,923	$0
Vision Insurance	$226,750	$226,750	$0
Basic Life and ADD Insurance	$77,763	$77,763	$0
STD Insurance	$569,175	$569,175	$0
LTD Insurance	$357,487	$357,487	$0
EAP with Counseling (Aetna Resources for Living)	$30,858	$81,858	$51,000
HSA Employer Contribution	$261,250	$334,400	$73,150
Medical Stipends	$326,400	$326,400	$0
FSA Administration	$26,240	$26,240	$0
COBRA Administration	$7,247	$7,247	$0
Spousal Surcharge	($247,200)	$0	$247,200
Total*	**$27,533,364**	**$30,064,539**	**$2,531,175**

*Totals may not add up due to rounding

CalOptima Health's contributions to the total group health and welfare benefits package totals approximately $27,715,656. Additional details are provided by benefit plan for CY 2024 in Attachment A.

Contributions to Benefits	**CY 2023**	**CY 2024**	**Difference (CY 2024 – CY 2023)**
CalOptima Health's Share	$25,184,481	$27,715,656	$2,531,175
Employees' Share	$2,348,884	$2,348,884	$0
Total	**$27,533,365**	**$30,064,539**	**$2,531,175**

Medical

Blue Shield of California: In CY 2023, Blue Shield of California indicated a blended rate cap of 11.9% for CY 2024. However, the premium renewals were lower than anticipated, resulting in an overall increase of 10.8%, or $1,319,943 in additional premiums. The Blue Shield HMO Active and Early Retiree rates are renewing at a 10.6% increase or $995,899, and the Blue Shield PPO and HDHP Active

Back to Agenda

and Early Retiree plans are renewing at an 11.4% increase or $324,044. Although rates increased, staff recommends employee contributions remain unchanged to enhance recruitment and retention efforts during a period of inflation and competition in the labor market.

Kaiser: Kaiser proposed a renewal increase of 6.9% or $830,319 for active and early retirees and an increase of 16.5% or $9,563 for the Senior Advantage HMO Plan. Although rates increased, staff recommends employee contributions remain unchanged to enhance recruitment and retention efforts during a period of inflation and competition in the labor market.

AmWins PPO**:** AmWins provides PPO supplemental coverage to Medicare-eligible retirees and dependents. While AmWins rates have not yet been released, staff recommends that the employee/retiree contribution rates remain at the same level for CY 2024.

Wellness Funding: As part of their proposal, Blue Shield of California will provide a $75,000 wellness subsidy to assist in improving the health and wellness of CalOptima Health's employees, focusing on behavior change and health status improvement, and creating a health and wellness program strategy leading toward a culture of well-being. Blue Shield of California wellness funds may be used to reimburse CalOptima Health for employee health and wellness program expenses, including, but not limited to educational workshops and employee wellness activities.

For CY 2024, the proposed wellness activities may include the following:

CY 2024 Wellness Program/Event/Activity	**Estimated Cost**
Wellness Month (Wellness Activities)	$5,000
Health Education/Wellness Incentives	$5,000
Health & Fitness Video Library	$6,000
Early Detection Screenings	$24,000
Wellness App and Wellness Challenges	$20,000
Health & Wellness Fair	$15,000
Total	**$75,000**

Dental
Blue Shield: Renewal came at no rate change due to a rate guarantee through December 31, 2024. Staff recommends no change to employee contributions.

Vision
VSP**:** Renewal came at no rate change due to a rate guarantee through December 31, 2025. Staff recommends no change to employee contributions.

Other Ancillary Plans
New York Life & Disability:
Basic Life/ADD: Renewal came at no rate change due to a rate guarantee through December 31, 2024.

Back to Agenda

Voluntary Life/ADD: Renewal came at no rate change due to a rate guarantee through December 31, 2024. Staff recommends no change to employee contribution rates.

Short-Term Disability and Long-Term Disability: Renewal came at no rate change due to a rate guarantee through December 31, 2024.

Employee Assistance Program: Renewal came at no rate change due to a rate guarantee through December 31, 2025, and continues to include the option to purchase on-site and virtual counseling services. Utilizing wellness funds provided by Blue Shield of California, counseling services were introduced in CY 2023. Immediately upon launching these services, all appointments were filled approximately one month out. In response, staff contracted for additional counseling hours, which were still met with high employee demand. Due to the interest in and value of the on-site and virtual counseling services introduced in CY 2023, staff recommends $51,000 to fund on-site and virtual counseling and mental health services through Aetna Resources for Living in CY 2024.

Health Savings Account
CalOptima Health offers an HSA for employees enrolled in the HDHP medical plan. The Internal Revenue Service (IRS) has provided inflation-adjusted limits for HSAs and HDHPs for CY 2024. The minimum deductible amount for HDHPs increases to $1,600 for self-only coverage and $3,200 for family coverage (up from $1,500 for self-only coverage and $3,000 for family coverage in 2023). Staff recommends matching the employer contribution to the HSA to this IRS minimum deductible amount and frontloading this contribution in the first pay period of 2024 in order to attract and retain talent in 2024. CalOptima Health will prorate the amount for new hires based on the date of hire. Assuming all employees currently in the plan continue this coverage, the annual amount will be $334,400.

Medical Stipends
CalOptima Health offers a medical stipend of $100 per pay period (for 24 pay periods) as a cost saving measure to CalOptima Health and an incentive for employees who have medical coverage outside of CalOptima Health. Employees must submit proof of outside coverage in order to be eligible for this benefit.

Spousal Surcharge
In previous years, employees who enrolled their spouse or domestic partner under a CalOptima Health medical plan were subject to a $50 bi-monthly spousal surcharge if their spouse or domestic partner was eligible to enroll in other medical coverage elsewhere. Staff recommends eliminating the spousal surcharge to enhance recruitment and retention efforts. With 206 employees currently subject to the spousal surcharge, the annual financial impact of eliminating the surcharge is anticipated to be approximately $247,200.

Employer and Employee Contribution Comparison
CalOptima Health's and individual employee's share of healthcare premiums differ depending on the employee's elections. As set forth in the attached presentation, employer premium contributions for full time employees range from 83.6% to 97.4% and the premium contribution rates for employees and retirees range from 2.6% to 16.4%. The methodology used to calculate the employer and employee contributions is intended to aid management in attracting and retaining talented employees.

Back to Agenda

Staff Recommendations

Last year's proposed employee contribution strategy included CalOptima Health covering the increase in premiums after benefiting from reduced premiums in CY 2021. For CY 2024, staff recommends no changes to the employee/retiree contribution rates to continue ensuring that CalOptima Health remains competitive with market trends and meets its ongoing obligation to provide a comprehensive benefits package to attract and retain talent during a period of inflation and competitive labor market.

Fiscal Impact

The fiscal impact for group health insurance policies for CalOptima Health employees and retirees in CY 2024 is estimated at a total cost not to exceed $32.0 million. The recommended action to provide group health insurance policies for CalOptima Health employees and retirees for the period of January 1, 2024, through June 30, 2024, and associated anticipated expenditures are budgeted items in the CalOptima Health Fiscal Year (FY) 2023-24 Operating Budget approved by the Board on June 1, 2023. Management will include funding for group health insurance policies and wellness benefits for the period of July 1, 2024, through December 31, 2024, in the CalOptima Health FY 2024-25 Operating Budget.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by the Recommended Action
2. Attachment A: CalOptima Health 2024 Renewal Executive Summary

/s/ Michael Hunn *08/31/2023*
Authorized Signature **Date**

Back to Agenda

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Aetna Resources for Living EAP	10260 Meanley Drive	San Diego	CA	92131
Alliant Insurance Services	333 S. Hope Street, Suite 3650	Los Angeles	CA	90071
Amwins Group Benefits	50 Whitecap Dr.	North Kingstown	RI	02852
Blue Shield of California	100 N. Pacific Coast Hwy, 20th Floor	El Segundo	CA	90245
Kaiser Permanente	1851 E. First Street, Suite 1100	Santa Ana	CA	92705
New York Life Insurance Company	400 N. Brand Boulevard, 4th Floor	Glendale	CA	91203
PRISMHealth	75 Iron Point Circle, Suite 200	Folsom	CA	95630
VSP	333 Quality Drive	Rancho Cordova	CA	95670
WEX Health Inc	4321 20th Ave S	Fargo	ND	58103

CalOptima 2024 Renewal Executive Summary

August 7, 2023

Brigette Hoey, Chief Human Resources Officer

Back to Agenda

Back to Item

Alliant Insurance Services

Executive Summary

Medical Renewals

Blue Shield of California

Blue Shield proposes an overall increase of 10.8% or $1,319,943 in additional premium for plan year 2024. The proposed renewal increase is below the second year rate cap of 11.9% included in their initial proposal. The proposed renewal action was based on the medical claims experience incurred through May, 2023. The renewal calculation was reviewed and validated by Alliant's Underwriting Team to ensure accuracy. In addition, Blue Shield agreed to include a $75,000 wellness subsidy with their proposed renewal.

Kaiser Permanente

Kaiser proposed renewal action is a 6.9% increase on the active and early retiree HMO plan and a 16.5% on the Senior Advantage HMO plan, resulting in an overall additional premium of $839,882. The proposed renewal action is favorable, and it's based on a decrease in overall plan utilization. The average Kaiser renewals for 2024 range between 5% to 25%, driven by current inflationary pressures.

AmWins

The AmWins renewal is pending Centers of Medicare and Medicaid Services (CMS) approval.

Medical Marketing

To mitigate the medical renewal increase, Alliant released a targeted medical marketing to PRISM Health Program. The marketing results validated the renewal actions proposed by the carriers and did not yield financial savings.

Renewal Recommendation

Renew the current Blue Shield of CA plans, effective January 1, 2024, with no changes to the current plan options and benefit levels. Renew the current Kaiser HMO, and Kaiser Sr. Advantage plans with no changes in plan design.

Back to Agenda

Back to Item

Alliant Insurance Services

Executive Summary

Ancillary Renewals

Dental Plans	The Blue Shield dental HMO and PPO are in a rate guarantee that expires on December 31, 2024 and will renew with a rate pass.
Vision Plans	The VSP vision plans are in a rate guarantee that expires on December 31, 2025 and will renew with a rate pass.
Life and Disability	The New York Life (NYL) Basic and Supplemental Life and Disability plans are in are a rate guarantee that expires on December 31, 2024 and will renew with a rate pass.
Ancillary Marketing	To ensure that the current ancillary plans are competitive, Alliant released a targeted marketing to PRISM Health Program. The marketing results validated the renewal actions and did not yield significant financial savings compared to the renewal.
Employee Assistance Program	The Aetna Resources for Living EAP and onsite counseling is in a rate guarantee that expires on December 31, 2025 and will renew with a rate pass.
Renewal Recommendation	Renew the dental, vision, life, disability and EAP plans with the current carriers, effective January 1, 2024, with no changes to the current plan options and benefit levels.

Back to Agenda

Back to Item

Alliant Insurance Services

Executive Summary

Miscellaneous Recommendations

FSA & COBRA Administrator	WEX Health: The FSA & COBRA plan administration fees are renewing level for the following plan year. Renewal Recommendation: Renew FSA and COBRA administration with WEX Health.
Employer HSA Contribution	Increase the annual employer HSA contribution to $1,600 for single and $3,200 for family coverage, to align with the increased HDHP deductibles. Front load the contributions the first paycheck in January, 2024 and pro-rate the amount for new hires based on date of hire.
Employer Contribution	Keep the current employer contribution level the same for 2024.
Spousal Surcharge	Eliminate the spousal surcharge for plan year 2024.
Medical Waiver Benefit	Keep the benefit amount level at $200 per month.

Back to Agenda

Back to Item

2024 Renewal Summary

Line of Coverage (Actives & Retirees)	EE	Current	Renewal	$ Change	% Change
Kaiser HMO - Actives	739	$11,769,261	$12,591,648	$822,387	7.0%
Kaiser HMO - Early Retirees	4	$113,405	$121,337	$7,932	7.0%
Kaiser - KPSA	20	$57,792	$67,355	$9,563	16.5%
AmWins Medicare	31	$260,224	*Pending* $260,224	$0	0.0%
Blue Shield Full HMO	331	$6,512,241	$7,205,145	$692,904	10.6%
Blue Shield Trio HMO	180	$2,847,664	$3,150,659	$302,995	10.6%
Blue Shield PPO	5	$96,279	$107,226	$10,947	11.4%
Blue Shield HDHP with HSA	133	$2,750,605	$3,063,702	$313,097	11.4%
Blue Shield Dental PPO	1144	$1,371,125	*Rate Guarantee* $1,371,125	$0	0.0%
Blue Shield DHMO	390	$118,798	*Rate Guarantee* $118,798	$0	0.0%
VSP Vision	1396	$226,750	*Rate Guarantee* $226,750	$0	0.0%
New York Life Basic Life AD&D	1568	$77,763	*Rate Guarantee* $77,763	$0	0.0%
New York Life STD	1569	$569,175	*Rate Guarantee* $569,175	$0	0.0%
New York Life LTD	1569	$357,487	*Rate Guarantee* $357,487	$0	0.0%
Aetna RFL	1568	$30,858	$30,858	$0	0.0%
COBRA Administration	1342	$7,247	$7,247	$0	0.0%
Flexible Spending Account	660	$26,240	$26,240	$0	0.0%
TOTAL ANNUAL PREMIUM		**$27,192,915**	**$29,352,739**		
ANNUAL DOLLAR CHANGE FROM CURRENT **ANNUAL PERCENTAGE CHANGE FROM CURRENT**			**$2,159,825** **7.9%**		

Back to Agenda

Back to Item

Recommended Employer Contributions

Back to Agenda

Back to Item

Recommended ER Contributions: Medical Plans

Employee Contributions	Lives	Current Contributions Total	Current Contributions ER Cost	Current Contributions EE Cost	Current Contributions EE %	Renewal Contributions (No change in EE contributions) Total	Renewal Contributions (No change in EE contributions) ER Cost	Renewal Contributions (No change in EE contributions) EE Cost	Renewal Contributions (No change in EE contributions) EE %
Kaiser HMO - Actives									
EE Only	279	$693.03	$634.46	$58.57	8.5%	$741.46	$682.89	$58.57	7.9%
EE + Spouse	100	$1,386.06	$1,268.92	$117.14	8.5%	$1,482.92	$1,365.78	$117.14	7.9%
EE + Child(ren)	166	$1,316.75	$1,205.47	$111.28	8.5%	$1,408.75	$1,297.47	$111.28	7.9%
EE + Family	194	$2,217.68	$2,030.25	$187.43	8.5%	$2,372.64	$2,185.21	$187.43	7.9%
Annual Premium	739	$11,769,261	$10,774,594	$994,667		$12,591,648	$11,596,981	$994,667	
Kaiser HMO - Early Retirees									
EE Only	0	$1,038.51	$979.94	$58.57	5.6%	$1,111.15	$1,052.58	$58.57	5.3%
EE + Spouse	2	$2,077.02	$1,959.88	$117.14	5.6%	$2,222.30	$2,105.16	$117.14	5.3%
EE + Child(ren)	1	$1,973.16	$1,861.88	$111.28	5.6%	$2,111.17	$1,999.89	$111.28	5.3%
EE + Family	1	$3,323.22	$3,135.79	$187.43	5.6%	$3,555.65	$3,368.22	$187.43	5.3%
Annual Premium	4	$113,405	$107,009	$6,396		$121,337	$114,941	$6,396	
Kaiser KPSA									
EE Only on Medicare	11	$166.07	$143.98	$22.09	13.3%	$193.55	$171.46	$22.09	13.3%
EE + Spouse both on Medicare	9	$332.14	$287.96	$44.18	13.3%	$387.10	$342.92	$44.18	13.3%
Annual Premium	20	$57,792	$50,104	$7,688		$67,355	$59,667	$7,688	
AmWins Medicare									
EE Only on Medicare	15	$461.39	$383.38	$78.01	16.9%	$461.39	$383.38	$78.01	16.9%
EE + Spouse both on Medicare	16	$922.78	$745.88	$176.90	19.2%	$922.78	$745.88	$176.90	19.2%
Annual Premium	31	$260,224	$212,218	$48,006		$260,224	$212,218	$48,006	

Recommended ER Contributions: Medical Plans

Employee Contributions		Current Contributions				Renewal Contributions No change in EE contributions			
		Total	ER Cost	EE Cost	EE %	Total	ER Cost	EE Cost	EE %
Blue Shield Full HMO									
EE Only	106	$798.70	$740.13	$58.57	7.3%	$883.68	$825.11	$58.57	6.6%
EE + Spouse	42	$1,748.32	$1,631.18	$117.14	6.7%	$1,934.34	$1,817.20	$117.14	6.1%
EE + Child(ren)	79	$1,579.76	$1,468.48	$111.28	7.0%	$1,747.85	$1,636.57	$111.28	6.4%
EE + Family	104	$2,498.02	$2,310.59	$187.43	7.5%	$2,763.81	$2,576.38	$187.43	6.8%
Annual Premium	331	$6,512,241	$6,039,297	$472,944		$7,205,145	$6,732,201	$472,944	
Blue Shield Trio HMO									
EE Only	68	$641.12	$622.40	$18.72	2.9%	$709.34	$690.62	$18.72	2.6%
EE + Spouse	17	$1,403.38	$1,356.14	$47.24	3.4%	$1,552.70	$1,505.46	$47.24	3.0%
EE + Child(ren)	28	$1,268.07	$1,225.40	$42.67	3.4%	$1,402.99	$1,360.32	$42.67	3.0%
EE + Family	67	$2,005.16	$1,936.78	$68.38	3.4%	$2,218.51	$2,150.13	$68.38	3.1%
Annual Premium	180	$2,847,664	$2,753,441	$94,222		$3,150,659	$3,056,437	$94,222	
Blue Shield PPO									
EE Only	4	$1,346.52	$1,146.40	$200.12	14.9%	$1,499.62	$1,299.50	$200.12	13.3%
EE + Spouse	0	$2,916.48	$2,439.99	$476.49	16.3%	$3,248.08	$2,771.59	$476.49	14.7%
EE + Child(ren)	1	$2,637.18	$2,206.21	$430.97	16.3%	$2,937.03	$2,506.06	$430.97	14.7%
EE + Family	0	$4,171.86	$3,457.10	$714.76	17.1%	$4,646.20	$3,931.44	$714.76	15.4%
Annual Premium	5	$96,279	$81,502	$14,777		$107,226	$92,449	$14,777	
Blue Shield HDHP									
EE Only	57	$967.26	$863.61	$103.65	10.7%	$1,077.35	$973.70	$103.65	9.6%
EE + Spouse	24	$2,030.56	$1,738.18	$292.38	14.4%	$2,261.98	$1,969.60	$292.38	12.9%
EE + Child(ren)	24	$1,837.50	$1,572.96	$264.54	14.4%	$2,046.56	$1,782.02	$264.54	12.9%
EE + Family	28	$2,901.78	$2,373.11	$528.67	18.2%	$3,231.95	$2,703.28	$528.67	16.4%
Annual Premium	133	$2,750,605	$2,341,685	$408,920		$3,063,702	$2,654,782	$408,920	
MEDICAL TOTAL	**1,443**	**$24,407,472**	**$22,359,851**	**$2,047,621**	**8.4%**	**$26,567,297**	**$24,519,676**	**$2,047,621**	**7.7%**
DOLLAR CHANGE FROM CURRENT						**$2,159,825**	**$2,159,825**	**$0**	
PERCENT CHANGE FROM CURRENT						**8.8%**	**9.7%**	**0.0%**	

Back to Agenda

Back to Item

Recommended ER Contributions: Ancillary Plans

Employee Contributions	Lives	Total	ER Cost	EE Cost	EE %	Total	ER Cost	EE Cost	EE %
Blue Shield Dental PPO									
EE Only	400	$42.85	$37.65	$5.20	12.1%	$42.85	$37.65	$5.20	12.1%
EE + Spouse	186	$85.15	$69.43	$15.72	18.5%	$85.15	$69.43	$15.72	18.5%
EE + Child(ren)	197	$109.38	$89.18	$20.20	18.5%	$109.38	$89.18	$20.20	18.5%
EE + Family	361	$165.47	$133.93	$31.54	19.1%	$165.47	$133.93	$31.54	19.1%
Annual Premium	1144	$1,371,125	$1,126,694	$244,431		$1,371,125	$1,126,694	$244,431	
Blue Shield DHMO									
EE Only	160	$11.69	$11.69	$0.00	0.0%	$11.69	$11.69	$0.00	0.0%
EE + Spouse	56	$23.20	$23.20	$0.00	0.0%	$23.20	$23.20	$0.00	0.0%
EE + Child(ren)	73	$29.81	$29.81	$0.00	0.0%	$29.81	$29.81	$0.00	0.0%
EE + Family	101	$45.09	$45.09	$0.00	0.0%	$45.09	$45.09	$0.00	0.0%
Annual Premium	390	$118,798	$118,798	$0		$118,798	$118,798	$0	
VSP Vision (Core)									
EE Only	373	$6.71	$6.71	$0.00	0.0%	$6.71	$6.71	$0.00	0.0%
EE + Spouse	147	$10.42	$9.42	$1.00	9.6%	$10.42	$9.42	$1.00	9.6%
EE + Child(ren)	156	$10.85	$9.35	$1.50	13.8%	$10.85	$9.35	$1.50	13.8%
EE + Family	278	$17.37	$15.37	$2.00	11.5%	$17.37	$15.37	$2.00	11.5%
Annual Premium	954	$126,672	$115,428	$11,244		$126,672	$115,428	$11,244	
VSP Vision (Buy-Up)									
EE Only	160	$11.21	$6.71	$4.50	40.1%	$11.21	$6.71	$4.50	40.1%
EE + Spouse	83	$17.41	$9.42	$7.99	45.9%	$17.41	$9.42	$7.99	45.9%
EE + Child(ren)	62	$18.13	$9.35	$8.78	48.4%	$18.13	$9.35	$8.78	48.4%
EE + Family	137	$29.03	$15.37	$13.66	47.1%	$29.03	$15.37	$13.66	47.1%
Annual Premium	442	$100,078	$54,490	$45,587		$100,078	$54,490	$45,587	
NYL Life and Disability									
Basic Life and AD&D	1568	$77,762.62	$77,762.62	$0.00	0.0%	$77,762.62	$77,762.62	$0.00	0.0%
Short Term Disability	1568	$569,175.21	$569,175.21	$0.00	0.0%	$569,175.21	$569,175.21	$0.00	0.0%
Long Term Disability	1568	$357,487.07	$357,487.07	$0.00	0.0%	$357,487.07	$357,487.07	$0.00	0.0%

Back to Agenda

Back to Item

Recommended ER Contributions: Ancillary Plans

Aetna RFL Employee Assistance Program										
Annual Premium	1568	$30,858.00	$30,858.00	$0.00	0.0%		$30,858.00	$30,858.00	$0.00	0.0%
Aetna RFL Counseling Services										
Annual Premium	1568	$0.00	$0.00	$0.00	0.0%		$51,000.00	$51,000.00	$0.00	0.0%
Employer HSA Contribution										
Annual Contribution	133	$261,250.00	$261,250.00	$0.00	0.0%		$334,400.00	$334,400.00	$0.00	0.0%
WEX FSA Administration										
Annual Administrative Fee	660	$26,240.00	$26,240.00	$0.00	0.0%		$26,240.00	$26,240.00	$0.00	0.0%
WEX COBRA Administration										
Annual Administrative Fee	1342	$7,247.00	$7,247.00	$0.00	0.0%		$7,247.00	$7,247.00	$0.00	0.0%
Medical Waiver Benefit										
Annual Contribution	135	$326,400.00	$326,400.00	$0.00	0.0%		$326,400.00	$326,400.00	$0.00	0.0%
Spousal Surcharge Elimination										
Annual Amount	206	($247,200.00)	($247,200.00)	$0.00	0.0%		$0.00	$0.00	$0.00	0.0%
Ancillary Total		**$3,125,893**	**$2,824,630**	**$301,263**	**9.6%**		**$3,497,243**	**$3,195,980**	**$301,263**	**8.6%**
GRAND TOTAL (Medical and Ancillary):		**$27,533,365**	**$25,184,481**	**$2,348,884**	**8.5%**		**$30,064,539**	**$27,715,656**	**$2,348,884**	**7.8%**
DOLLAR CHANGE FROM CURRENT							**$2,531,175**	**$2,531,175**	**$0**	
PERCENT CHANGE FROM CURRENT							**9.2%**	**10.1%**	**0.0%**	

Back to Agenda

Back to Item

Disclosures

Alliant embraces a policy of transparency with respect to its compensation from insurance transactions. Details on our compensation policy, including the types of income that Alliant may earn on a placement, are available on our website at www.alliant.com. For a copy of our policy or for any inquiries regarding compensation issues pertaining to your account you may also contact us at: Alliant Insurance Services, Inc., Attention: General Counsel, 701 B Street, 6th Floor, San Diego, CA 92101.

Plans and rates presented are generally effective 01/01/2024 through 12/31/2024.
Rates quoted assume current employer contribution levels and participation levels unless otherwise stated. Final rates will be based on final enrollment underwriting. Updated claims experience or other information may be required to finalize rates. If group demographics, enrollment levels or employer contributions change, rates may change or the quote may be withdrawn.

In general, employees must be actively act work on the effective date of the plan. When implementing new coverage, employees who are not actively at work will not be covered under the plan until they return to active state. It may be possible to waive the actively at work provision.
This proposal should not be interpreted as inclusive of all plan provisions and limitations. For further details, refer to the insurance carrier proposals and carrier plan documents. Benefit coverage and eligibility provisions for fully insured health plans may vary from state to state, based on state mandates. Illustrated enrollment is based on the information provided (employee census, current premium statement and or carrier renewal).
Coverage is not in effect until it is approved by the insurance carrier's underwriter.

Analyzing insurers' over-all performance and financial strength is a task that requires specialized skills and in-depth technical understanding of all aspects of insurance company finances and operations. Insurance brokerages such as Alliant typically rely upon rating agencies for this type of market analysis. A.M. Best has been an industry leader in this area for many decades, utilizing a combination of quantitative and qualitative analysis of the information available in formulating their ratings. Alliant's standard protocol is to only place coverage with carriers with no less than an "A-"- rating from A.M. Best. However, where Alliant determines that it is prudent to consider coverage with a lower rated carrier, the financial rating of the carrier is to be disclosed to the client. Should Alliant becomes aware of a carrier's rating dropping below "A-" mid-policy period we will review and advise you of the situation and consider if an alternative carrier can be reasonably provided prior to renewal.
A.M. Best has an extensive database of nearly 6,000 Life/Health, Property Casualty and International companies. You can visit them at www.ambest.com.

Back to Agenda Back to Item

Back to Agenda

Back to Item

CalOptima Health Board Action Agenda Referral

Action To Be Taken September 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

19. Authorize Action Related to California Public Employees' Retirement System Unfunded Accrued Liability

Contacts

Brigette Hoey, Chief Human Resources Officer, (714) 246-8405
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action

Authorize the Chief Executive Officer (CEO) to execute a one-time additional discretionary payment of $49,999,717 to fully fund the California Public Employees' Retirement System Unfunded Accrued Liability balance as of June 30, 2022.

Background

In October 1995, CalOptima Health entered into a contract with the California Public Employees' Retirement System (CalPERS) to provide employee pension benefits in lieu of Social Security. As a defined benefit plan, CalPERS provides a fixed, pre-established benefit for employees at retirement based on the employee's years of service, age, and final compensation.

Retirement benefits are funded by required employee and employer contributions, as well as CalPERS investment earnings that make up the largest portion of the funding. The minimum required employer contribution is based on the annual actuarial valuation report, which discloses the funded status of the plan, and varies from year to year. Actuarial valuations are based on assumptions regarding future plan experience, including investment return, salary growth, longevity among retirees, and other factors. Each actuarial valuation reflects all prior differences between actual and assumed experience and adjusts the contribution requirements as needed.

In a defined benefit pension plan such as CalPERS, there is an Unfunded Accrued Liability (UAL) that represents the difference between the estimated cost of future benefits and the assets that have been set aside to pay for those benefits. As part of the employer contribution, CalOptima Health is also required to make minimum annual contribution towards the plan's UAL.

Discussion

CalPERS allows agencies to make additional discretionary payments (ADPs) at any time and in any amount. These optional payments serve to reduce the UAL and future required contributions and can result in significant long-term savings in interest costs. New unfunded liabilities can emerge in future years due to assumption or methodology changes, changes in plan provisions, and actuarial experience different than what was assumed.

In August 2023, CalPERS released its latest actuarial report of the valuation results as of June 30, 2022. The actuarial valuation report presented that CalOptima Health's total UAL was $49,999,717 with the

Back to Agenda

funded ratio at 82.6% as of June 30, 2022. These estimates assume an expected investment return of 6.8%. The report further details that based on the current 23-year amortization schedule, CalOptima Health would save approximately $44.5 million in interest by fully funding the total UAL in a one-time ADP contribution in Fiscal Year (FY) 2023-24.

In August 2023, staff met with CalPERS to discuss funding options that will best suit CalOptima Health's pension needs and protect financial resources. After evaluating different options, staff recommends a proactive approach to initiate a $49,999,717 ADP to fund CalOptima Health UAL at 100% to mitigate rising pension liability risks and achieve savings in interest costs.

Fiscal Impact

There is no immediate fiscal impact to the CalOptima Health FY 2023-24 Operating Budget. The one-time ADP of $49,999,717 will reduce pension liabilities and decrease the current assets on CalOptima Health's balance sheet. It may impact CalOptima Health's future year income statement since the interest cost of pension expenses will be lower.

Rationale for Recommendation

These actions ensure that CalOptima Health remains fiscally responsible and prudent by reducing pension liabilities.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. CalPERS Annual Actuarial Valuation Report as of June 30, 2022

/s/ Michael Hunn *08/31/2023*
Authorized Signature **Date**

Back to Agenda

California Public Employees' Retirement System
Actuarial Office
400 Q Street, Sacramento, CA 95811 | Phone: (916) 795-3000 | Fax: (916) 795-2744
888 CalPERS (or **888**-225-7377) | TTY: (877) 249-7442 | www.calpers.ca.gov

July 2023

Miscellaneous Plan of the Orange County Health Authority (CalPERS ID: 7832606433)
Annual Valuation Report as of June 30, 2022

Dear Employer,

Attached to this letter is the June 30, 2022 actuarial valuation report for the rate plan noted above. **Provided in this report is the determination of the minimum required employer contributions for fiscal year (FY) 2024-25**. In addition, the report contains important information regarding the current financial status of the plan as well as projections and risk measures to aid in planning for the future.

Actuarial valuations are based on assumptions regarding future plan experience including investment return and payroll growth, eligibility for the types of benefits provided, and longevity among retirees. The CalPERS Board of Administration (board) adopts these assumptions after considering the advice of CalPERS actuarial and investment teams and other professionals. Each actuarial valuation reflects all prior differences between actual and assumed experience and adjusts the contribution requirements as needed. This valuation is based on an investment return assumption of 6.8%, which was adopted by the board in November 2021. Other assumptions used in this report are those recommended in the CalPERS Experience Study and Review of Actuarial Assumptions report from November 2021.

Required Contributions

The table below shows the minimum required employer contributions and the PEPRA member rate for FY 2024-25 along with an estimate of the required employer contribution for FY 2025-26. Employee contributions other than cost sharing (whether paid by the employer or the employee) are in addition to the results shown below. **The required employer contributions in this report do not reflect any cost sharing arrangement between the agency and the employees.**

Fiscal Year	Employer Normal Cost Rate	Employer Amortization of Unfunded Accrued Liability	PEPRA Member Contribution Rate
2024-25	8.80%	$3,045,985	8.25%
Projected Results			
2025-26	*8.8%*	*$3,615,000*	*TBD*

The actual investment return for FY 2022-23 was not known at the time this report was prepared. The projections above assume the investment return for that year would be 6.8%. ***To the extent the actual investment return for FY 2022-23 differs from 6.8%, the actual contribution requirements for FY 2025-26 will differ from those shown above.*** For additional details regarding the assumptions and methods used for these projections, please refer to the "Projected Employer Contributions" in the "Highlights and Executive Summary" section. This section also contains projected required contributions through FY 2029-30.

Changes from Previous Year's Valuations

There are no significant changes in actuarial assumptions or policies in the 2022 actuarial valuation. There may be changes specific to the plan such as contract amendments and funding changes.

Further descriptions of general changes are included in the "Highlights and Executive Summary" section and in Appendix A, "Actuarial Methods and Assumptions." The effects of any changes on the required contributions are included in the "Reconciliation of Required Employer Contributions" section.

Back to Agenda Back to Item

Questions

A CalPERS actuary is available to answer questions about this report. Other questions may be directed to the Customer Contact Center at (888)-CalPERS or (**888-225-7377**).

Sincerely,

SCOTT TERANDO, ASA, EA, MAAA, FCA, CFA
Chief Actuary, CalPERS

RANDALL DZIUBEK, ASA, MAAA
Deputy Chief Actuary, Valuation Services, CalPERS

Actuarial Valuation
as of June 30, 2022

for the
Miscellaneous Plan
of the
Orange County Health Authority

(CalPERS ID: 7832606433)
(Rate Plan ID: 1936)

Required Contributions
for Fiscal Year
July 1, 2024 – June 30, 2025

Back to Agenda Back to Item

Table of Contents

Actuarial Certification

To the best of my knowledge, this report is complete and accurate and contains sufficient information to disclose, fully and fairly, the funded condition of the Miscellaneous Plan of the Orange County Health Authority and satisfies the actuarial valuation requirements of Government Code section 7504. This valuation and related validation work was performed by the CalPERS Actuarial Office and is based on the member and financial data as of June 30, 2022 provided by the various CalPERS databases and the benefits under this plan with CalPERS as of the date this report was produced.

It is my opinion that the valuation has been performed in accordance with generally accepted actuarial principles, in accordance with standards of practice prescribed by the Actuarial Standards Board, and that the assumptions and methods, as prescribed by the CalPERS Board of Administration, are internally consistent and reasonable for this plan.

The undersigned is an actuary who satisfies the *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States* with regard to pensions.

KERRY J. WORGAN, MAAA, FSA, FCIA
Supervising Actuary, CalPERS

Back to Agenda Back to Item

Highlights and Executive Summary

- **Introduction**
- **Purpose**
- **Required Contributions**
- **Additional Discretionary Employer Contributions**
- **Funded Status – Funding Policy Basis**
- **Projected Employer Contributions**
- **Cost**
- **Changes Since the Prior Year's Valuation**
- **Subsequent Events**

Introduction

This report presents the results of the June 30, 2022 actuarial valuation of the Miscellaneous Plan of the Orange County Health Authority of the California Public Employees' Retirement System (CalPERS). This actuarial valuation sets the minimum required contributions for fiscal year (FY) 2024-25.

Purpose

This report documents the results of the actuarial valuation prepared by the CalPERS Actuarial Office using data as of June 30, 2022. The purpose of the valuation is to:

- Set forth the assets and accrued liabilities of this rate plan as of June 30, 2022;
- Determine the minimum required employer contributions for this rate plan for FY July 1, 2024 through June 30, 2025;
- Determine the required member contribution rate for FY July 1, 2024 through June 30, 2025 for employees subject to the California Public Employees' Pension Reform Act of 2013 (PEPRA); and
- Provide actuarial information as of June 30, 2022 to the CalPERS Board of Administration (board) and other interested parties.

The pension funding information presented in this report should not be used in financial reports subject to Governmental Accounting Standards Board (GASB) Statement No. 68 for an Agent Employer Defined Benefit Pension Plan. A separate accounting valuation report for such purposes is available from CalPERS and details for ordering are available on the CalPERS website (www.calpers.ca.gov).

The measurements shown in this actuarial valuation may not be applicable for other purposes. The agency should contact the plan actuary before disseminating any portion of this report for any reason that is not explicitly described above.

Future actuarial measurements may differ significantly from the current measurements presented in this report due to such factors as the following: plan experience differing from that anticipated by the economic or demographic assumptions; changes in economic or demographic assumptions; changes in actuarial policies; changes in plan provisions or applicable law; and differences between the required contributions determined by the valuation and the actual contributions made by the agency.

Assessment and Disclosure of Risk

This report includes the following risk disclosures consistent with the guidance of Actuarial Standards of Practice No. 51 and recommended by the California Actuarial Advisory Panel (CAAP) in the Model Disclosure Elements document:

- A "Scenario Test," projecting future results under different investment income returns.
- A "Sensitivity Analysis," showing the impact on current valuation results using alternative discount rates 5.8% and 7.8%.
- A "Sensitivity Analysis," showing the impact on current valuation results assuming rates of mortality are 10% lower or 10% higher than our current post-retirement mortality assumptions adopted in 2021.
- Plan maturity measures indicating how sensitive a plan may be to the risks noted above.

Back to Agenda Back to Item

Required Contributions

Required Employer Contributions	Fiscal Year 2024-25
Employer Normal Cost Rate	**8.80%**
Plus	
Required Payment on Amortization Bases	**$3,045,985**
Paid either as	
1) Monthly Payment	**$253,832**
Or	
2) Annual Prepayment Option*	**$2,947,421**
Required PEPRA Member Contribution Rate	**8.25%**

The total minimum required employer contribution is the sum of the Plan's Employer Normal Cost Rate (expressed as a percentage of payroll and paid as payroll is reported) plus the Employer Unfunded Accrued Liability (UAL) Contribution Amount (billed monthly (1) or prepaid annually (2) in dollars).

** Only the UAL portion of the employer contribution can be prepaid **(which must be received in full no later than July 31)**.*

For additional detail regarding the determination of the required contribution for PEPRA members, see "PEPRA Member Contribution Rates" in the "Liabilities and Contributions" section. Required member contributions for Classic members can be found in Appendix B.

	Fiscal Year 2023-24	Fiscal Year 2024-25
Normal Cost Contribution as a Percentage of Payroll		
Total Normal Cost	16.70%	16.73%
Employee Contribution[1]	7.53%	7.93%
Employer Normal Cost[2]	9.17%	8.80%
Projected Annual Payroll for Contribution Year	$116,073,531	$127,492,517
Estimated Employer Contributions Based On Projected Payroll		
Total Normal Cost	$19,384,280	$21,329,498
Offset Due to Employee Contributions	8,740,337	10,110,157
Employer Normal Cost	10,643,943	11,219,341
Unfunded Liability Contribution	1,940,732	3,045,985
% of Projected Payroll (illustrative only)	1.67%	2.39%
Estimated Total Employer Contribution	$12,584,675	$14,265,326
% of Projected Payroll (illustrative only)	10.84%	11.19%

[1] For classic members, this is the percentage specified in the Public Employees' Retirement Law, net of any reduction from the use of a modified formula or other factors. For PEPRA members, the member contribution rate is based on 50% of the normal cost. A development of PEPRA member contribution rates can be found in the "Liabilities and Contributions" section. Employee cost sharing is not shown in this report.

[2] The Employer Normal Cost is a blended rate for all benefit groups in the plan. For a breakout of normal cost by benefit group, see "Normal Cost by Benefit Group" in the "Liabilities and Contributions" section.

Back to Agenda Back to Item

Additional Discretionary Employer Contributions

The minimum required employer contribution towards the Unfunded Accrued Liability (UAL) for this rate plan for FY 2024-25 is $3,045,985. CalPERS allows agencies to make additional discretionary payments (ADPs) at any time and in any amount. These optional payments serve to reduce the UAL and future required contributions and can result in significant long-term savings. Agencies can also use ADPs to stabilize annual contributions as a fixed dollar amount, percent of payroll or percent of revenue.

Provided below are select ADP options for consideration. Making such an ADP during FY 2024-25 does not require an ADP be made in any future year, nor does it change the remaining amortization period of any portion of unfunded liability. For information on permanent changes to amortization periods, see the "Amortization Schedule and Alternatives" section of the report.

Agencies considering making an ADP should contact CalPERS for additional information.

Minimum Required Employer Contribution for Fiscal Year 2024-25

Estimated Normal Cost	Minimum UAL Payment	ADP	Total UAL Contribution	Estimated Total Contribution
$11,219,341	$3,045,985	$0	$3,045,985	$14,265,326

The minimum required contribution above is less than interest on the UAL. With no ADP the UAL is projected to increase over the following year. If the minimum UAL payment were split between interest and principal, the principal portion would be negative. This situation is referred to as **negative amortization**. If only the minimum required contribution is made, contributions are not expected to exceed interest on the UAL until FY 2025-26, as shown in the "Amortization Schedule and Alternatives" section of the report (see columns labelled Current Amortization Schedule).

Fiscal Year 2024-25 Employer Contribution Necessary to Avoid Negative Amortization

Estimated Normal Cost	Minimum UAL Payment	ADP[1]	Total UAL Contribution	Estimated Total Contribution
$11,219,341	$3,045,985	$470,815	$3,516,800	$14,736,141

Alternative Fiscal Year 2024-25 Employer Contributions for Greater UAL Reduction

Funding Horizon	Estimated Normal Cost	Minimum UAL Payment	ADP[1]	Total UAL Contribution	Estimated Total Contribution
20 years	$11,219,341	$3,045,985	$1,760,171	$4,806,156	$16,025,497
15 years	$11,219,341	$3,045,985	$2,560,815	$5,606,800	$16,826,141
10 years	$11,219,341	$3,045,985	$4,249,517	$7,295,502	$18,514,843
5 years	$11,219,341	$3,045,985	$9,499,997	$12,545,982	$23,765,323

[1] The ADP amounts are assumed to be made in the middle of the fiscal year. A payment made earlier or later in the fiscal year would have to be less or more than the amount shown to have the same effect on the UAL amortization.

Note that the calculations above are based on the projected Unfunded Accrued Liability as of June 30, 2024 as determined in the June 30, 2022 actuarial valuation. New unfunded liabilities can emerge in future years due to assumption or method changes, changes in plan provisions, and actuarial experience different than assumed. Making an ADP illustrated above for the indicated number of years will not result in a plan that is exactly 100% funded in the indicated number of years. Valuation results will vary from one year to the next and can diverge significantly from projections over a period of several years.

Back to Agenda Back to Item

Funded Status – Funding Policy Basis

The table below provides information on the current funded status of the plan under the funding policy. The funded status for this purpose is based on the market value of assets relative to the funding target produced by the entry age actuarial cost method and actuarial assumptions adopted by the board. The actuarial cost method allocates the total expected cost of a member's projected benefit (**Present Value of Benefits**) to individual years of service (the **Normal Cost**). The value of the projected benefit that is not allocated to future service is referred to as the **Accrued Liability** and is the plan's funding target on the valuation date. The **Unfunded Accrued Liability** (UAL) equals the funding target minus the assets. The UAL is an absolute measure of funded status and can be viewed as employer debt. The **funded ratio** equals the assets divided by the funding target. The funded ratio is a relative measure of the funded status and allows for comparisons between plans of different sizes.

	June 30, 2021	June 30, 2022
1. Present Value of Benefits	$416,528,477	$469,216,404
2. Entry Age Accrued Liability	249,962,336	286,699,719
3. Market Value of Assets (MVA)	239,427,253	236,700,002
4. Unfunded Accrued Liability (UAL) [(2) – (3)]	$10,535,083	$49,999,717
5. Funded Ratio [(3) / (2)]	95.8%	82.6%

A funded ratio of 100% (UAL of $0) implies that the funding of the plan is on target and that future contributions equal to the normal cost of the active plan members will be sufficient to fully fund all retirement benefits if future experience matches the actuarial assumptions. A funded ratio of less than 100% (positive UAL) implies that in addition to normal costs, payments toward the UAL will be required. Plans with a funded ratio greater than 100% have a negative UAL (or surplus) but are required under current law to continue contributing the normal cost in most cases, preserving the surplus for future contingencies.

Calculations for the funding target reflect the expected long-term investment return of 6.8%. If it were known on the valuation date that future investment returns will average something greater/less than the expected return, calculated normal costs and accrued liabilities provided in this report would be less/greater than the results shown. Therefore, for example, if actual average future returns are less than the expected return, calculated normal costs and UAL contributions will not be sufficient to fully fund all retirement benefits. Under this scenario, required future normal cost contributions will need to increase from those provided in this report, and the plan will develop unfunded liabilities that will also add to required future contributions. For illustrative purposes, funded statuses based on a 1% lower and higher average future investment return (discount rate) are as follows:

	1% Lower Average Return	Current Assumption	1% Higher Average Return
Discount Rate	5.8%	6.8%	7.8%
1. Present Value of Benefits	$585,014,460	$469,216,404	$383,332,665
2. Entry Age Accrued Liability	336,242,776	286,699,719	246,866,431
3. Market Value of Assets (MVA)	236,700,002	236,700,002	236,700,002
4. Unfunded Accrued Liability (UAL) [(2) – (3)]	$99,542,774	$49,999,717	$10,166,429
5. Funded Ratio [(3) / (2)]	70.4%	82.6%	95.9%

The "Risk Analysis" section of the report provides additional information regarding the sensitivity of valuation results to the expected investment return and other factors. Also provided in that section are measures of funded status that are appropriate for assessing the sufficiency of plan assets to cover estimated termination liabilities.

Projected Employer Contributions

The table below shows the required and projected employer contributions (before cost sharing) for the next six fiscal years. The projection assumes that all actuarial assumptions will be realized and that no further changes to assumptions, contributions, benefits, or funding will occur during the projection period. In particular, the investment return beginning with FY 2022-23 is assumed to be 6.80% per year, net of investment and administrative expenses. The projected normal cost percentages below reflect that the normal cost is expected to continue to decline over time as new employees are hired into lower cost benefit tiers. Future contribution requirements may differ significantly from those shown below. The actual long-term cost of the plan will depend on the actual benefits and expenses paid and the actual investment experience of the fund.

	Required Contribution	**Projected Future Employer Contributions (Assumes 6.80% Return for Fiscal Year 2022-23 and Beyond)**				
Fiscal Year	**2024-25**	**2025-26**	**2026-27**	**2027-28**	**2028-29**	**2029-30**
Normal Cost %	8.80%	8.8%	8.8%	8.7%	8.7%	8.7%
UAL Payment	$3,045,985	$3,615,000	$4,164,000	$4,612,000	$5,573,000	$5,664,000
*Total as a % of Payroll**	*11.19%*	*11.5%*	*11.8%*	*12.1%*	*12.6%*	*12.6%*
Projected Payroll	*$127,492,517*	*$131,062,308*	*$134,732,052*	*$138,504,550*	*$142,382,678*	*$146,369,392*

*Illustrative only and based on the projected payroll shown.

For ongoing plans, investment gains and losses are amortized using a 5-year ramp up. For more information, please see "Amortization of Unfunded Actuarial Accrued Liability" under "Actuarial Methods" in Appendix A. This method phases in the impact of the change in UAL over a 5-year period in order to reduce employer cost volatility from year to year. As a result of this methodology, dramatic changes in the required employer contributions in any one year are less likely. However, required contributions can change gradually and significantly over the next five years. In years when there is a large investment loss, the relatively small amortization payments during the ramp up period could result in contributions that are less than interest on the UAL (i.e. negative amortization) while the contribution impact of the increase in the UAL is phased in.

The required contribution for FY 2024-25 is less than interest on the UAL, a situation referred to as **negative amortization**, as explained in the "Additional Discretionary Employer Contributions" section earlier in this report. If only the minimum required contribution is made, contributions are not expected to exceed interest on the UAL until FY 2025-26, as shown in the "Amortization Schedule and Alternatives" section of the report (see columns labelled "Current Amortization Schedule").

For projected contributions under alternate investment return scenarios, please see the "Future Investment Return Scenarios" in the "Risk Analysis" section. Our online pension plan projection tool, Pension Outlook, is available in the Employers section of the CalPERS website. Pension Outlook can help plan and budget pension costs under various scenarios.

Back to Agenda Back to Item

Cost

Actuarial Determination of Plan Cost

Contributions to fund the plan are comprised of two components:

- Normal Cost, expressed as a percentage of total active payroll
- Amortization of the Unfunded Accrued Liability (UAL), expressed as a dollar amount

For fiscal years prior to 2017-18, the Amortization of UAL component was expressed as a percentage of total active payroll. Starting with FY 2017-18, the Amortization of UAL component is expressed as a dollar amount and invoiced on a monthly basis. There is an option to prepay this amount during July of each fiscal year.

The Normal Cost component is expressed as a percentage of active payroll with employer and employee contributions payable as part of the regular payroll reporting process.

The determination of both components requires complex actuarial calculations. The calculations are based on a set of actuarial assumptions which can be divided into two categories:

- Demographic assumptions (e.g., mortality rates, retirement rates, employment termination rates, disability rates)
- Economic assumptions (e.g., future investment earnings, inflation, salary growth rates)

These assumptions reflect CalPERS' best estimate of future experience of the plan and are long term in nature. We recognize that all assumptions will not be realized in any given year. For example, the investment earnings at CalPERS have averaged 6.9% over the 20 years ending June 30, 2022, yet individual fiscal year returns have ranged from -23.6% to +21.3%. In addition, CalPERS reviews all actuarial assumptions by conducting in-depth experience studies every four years, with the most recent experience study completed in 2021.

Changes Since the Prior Year's Valuation

Benefits

The standard actuarial practice at CalPERS is to recognize mandated legislative benefit changes in the first annual valuation following the effective date of the legislation. Voluntary benefit changes by plan amendment are generally included in the first valuation that is prepared after the amendment becomes effective, even if the valuation date is prior to the effective date of the amendment.

This valuation generally reflects plan changes by amendments effective before the date of the report. Please refer to the "Plan's Major Benefit Options" and Appendix B for a summary of the plan provisions used in this valuation. The effect of any mandated benefit changes or plan amendments on the unfunded liability is shown in the "(Gain) / Loss Analysis 6/30/21 – 6/30/22" and the effect on the employer contribution is shown in the "Reconciliation of Required Employer Contributions." It should be noted that no change in liability or contribution is shown for any plan changes which were already included in the prior year's valuation.

In 2022, SB 1168 increased the standard retiree lump sum death benefit from $500 to $2,000 for any death occurring on or after July 1, 2023. The impact, if any, is included in plan changes in the "(Gain) / Loss Analysis 6/30/21 – 6/30/22" and the "Reconciliation of Required Employer Contributions."

Actuarial Methods and Assumptions

There are no significant changes to the actuarial methods or assumptions for the June 30, 2022 actuarial valuation.

Subsequent Events

This actuarial valuation report reflects fund investment return through June 30, 2022 and statutory/regulatory changes and board actions through January 2023.

During the time period between the valuation date and the publication of this report, inflation has been significantly higher than the expected inflation of 2.3% per annum. Since inflation influences cost-of-living increases for retirees and beneficiaries and active member pay increases, higher inflation is likely to put at least some upward pressure on contribution requirements and downward pressure on the funded status in the June 30, 2023 valuation. The actual impact of higher inflation on future valuation results will depend on, among other factors, how long higher inflation persists. At this time, we continue to believe the long-term inflation assumption of 2.3% is appropriate.

To the best of our knowledge, there have been no other subsequent events that could materially affect current or future certifications rendered in this report.

Assets

- **Reconciliation of the Market Value of Assets**
- **Asset Allocation**
- **CalPERS History of Investment Returns**

Reconciliation of the Market Value of Assets

1.	Market Value of Assets as of 6/30/21 including Receivables	$239,427,253
2.	Change in Receivables for Service Buybacks	(6,998)
3.	Employer Contributions	11,688,269
4.	Employee Contributions	8,633,476
5.	Benefit Payments to Retirees and Beneficiaries	(3,657,290)
6.	Refunds	(675,423)
7.	Transfers	0
8.	Service Credit Purchase (SCP) Payments and Interest	8,460
9.	Administrative Expenses	(188,226)
10.	Miscellaneous Adjustments	0
11.	Investment Return (Net of Investment Expenses)	(18,529,519)
12.	Market Value of Assets as of 6/30/22 including Receivables	$236,700,002

Asset Allocation

CalPERS adheres to an Asset Allocation Strategy which establishes asset class allocation policy targets and ranges and manages those asset class allocations within their policy ranges. CalPERS Investment Belief No. 6 recognizes that strategic asset allocation is the dominant determinant of portfolio risk and return.

The asset allocation shown below reflects the allocation of the Public Employees' Retirement Fund (PERF) in its entirety. The assets for Orange County Health Authority Miscellaneous Plan are a subset of the PERF and are invested accordingly.

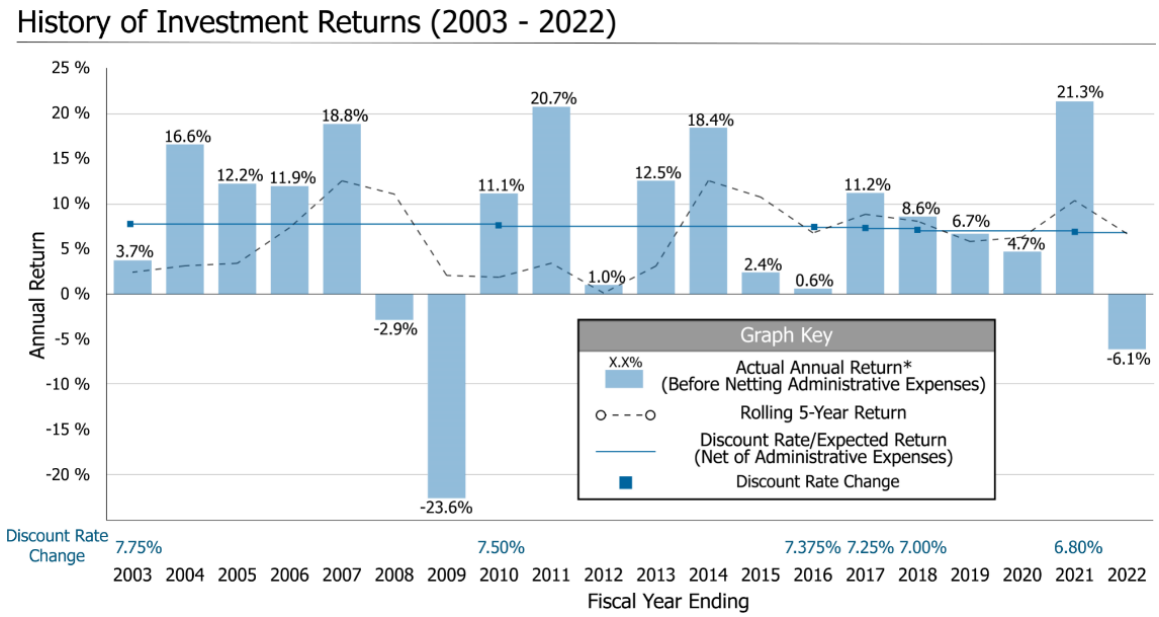
On November 17, 2021, the board adopted changes to the strategic asset allocation. The new allocation was effective July 1, 2022, and is shown below, expressed as a percentage of total assets.

Strategic Asset Allocation Policy Targets

Asset Class	Actual Allocation 9/30/2022	Policy Target Allocation effective 7/1/2022
Global Public Equity		
Market Capitalization Weighted	33.7%	30.0%
Factor Weighted	12.6%	12.0%
Private Equity	11.6%	13.0%
Income		
Treasuries	3.9%	5.0%
Mortgage-backed Securities	5.6%	5.0%
Investment Grade Corporates	5.8%	10.0%
High Yield Bonds	4.6%	5.0%
Emerging Market Sovereign Bonds	2.1%	5.0%
Total Fund Income	1.5%	-
Real Assets	17.1%	15.0%
Private Debt	1.8%	5.0%
Other Trust Level	3.8%	-
Leverage		
Strategic	(0.3%)	(5.0%)
Active	(3.8%)	-
Total Fund	**100.00%**	**100.0%**

CalPERS History of Investment Returns

The following is a chart with the 20-year historical annual returns of the PERF for each fiscal year ending on June 30 as reported by the Investment Office. Investment returns reported are net of investment expenses but without reduction for administrative expenses. The assumed rate of return, however, is net of both investment and administrative expenses. Also, the Investment Office uses a three-month lag on private equity and real assets for investment performance reporting purposes. This can lead to a timing difference in the returns below and those used for financial reporting purposes. The investment gain or loss calculation in this report relies on final assets that have been audited and are appropriate for financial reporting. Because of these differences, the effective investment return for funding purposes can be higher or lower than the return reported by the Investment Office shown here.



* As reported by the Investment Office with a 3-month lag on private equity and real assets.

The table below shows annualized investment returns of the PERF for various time periods ending on June 30, 2022 (figures reported are net of investment expenses but without reduction for administrative expenses). These returns are the annual rates that if compounded over the indicated number of years would equate to the actual time-weighted investment performance of the PERF. It should be recognized that in any given year the rate of return is volatile. The portfolio has an expected volatility of 12.1% per year based on the most recent Asset Liability Management study. The realized volatility is a measure of the risk of the portfolio expressed as the standard deviation of the fund's total monthly return distribution, expressed as an annual percentage. Due to their volatile nature, when looking at investment returns, it is more instructive to look at returns over longer time horizons.

History of CalPERS Compound Annual Rates of Return and Volatilities					
	1 year	**5 year**	**10 year**	**20 year**	**30 year**
Compound Annual Return	-6.1%	6.7%	7.7%	6.9%	7.7%
Realized Volatility	–	8.3%	7.1%	8.5%	8.6%

Back to Agenda Back to Item

Liabilities and Contributions

- **Development of Accrued and Unfunded Liabilities**
- **(Gain) / Loss Analysis 6/30/21 - 6/30/22**
- **Schedule of Amortization Bases**
- **Amortization Schedule and Alternatives**
- **Reconciliation of Required Employer Contributions**
- **Employer Contribution History**
- **Funding History**
- **Normal Cost by Benefit Group**
- **PEPRA Member Contribution Rates**

Development of Accrued and Unfunded Liabilities

	June 30, 2021	June 30, 2022
1. Present Value of Projected Benefits		
a) Active Members	$339,153,739	$368,055,574
b) Transferred Members	5,438,631	7,762,384
c) Separated Members	29,107,753	41,668,530
d) Members and Beneficiaries Receiving Payments	42,828,354	51,729,916
e) Total	$416,528,477	$469,216,404
2. Present Value of Future Employer Normal Costs	$88,000,835	$96,300,883
3. Present Value of Future Employee Contributions	$78,565,306	$86,215,802
4. Entry Age Accrued Liability		
a) Active Members [(1a) - (2) - (3)]	$172,587,598	$185,538,889
b) Transferred Members (1b)	5,438,631	7,762,384
c) Separated Members (1c)	29,107,753	41,668,530
d) Members and Beneficiaries Receiving Payments (1d)	42,828,354	51,729,916
e) Total	$249,962,336	$286,699,719
5. Market Value of Assets (MVA)	$239,427,253	$236,700,002
6. Unfunded Accrued Liability (UAL) [(4e) - (5)]	$10,535,083	$49,999,717
7. Funded Ratio [(5) / (4e)]	95.8%	82.6%

Back to Agenda Back to Item

(Gain)/Loss Analysis 6/30/21 – 6/30/22

To calculate the cost requirements of the plan, assumptions are made about future events that affect the amount and timing of benefits to be paid and assets to be accumulated. Each year, actual experience is compared to the expected experience based on the actuarial assumptions. This results in actuarial gains or losses, as shown below.

1.	**Total (Gain)/Loss for the Year**	
a)	Unfunded Accrued Liability (UAL) as of 6/30/21	$10,535,083
b)	Expected payment on the UAL during 2021-22	998,803
c)	Interest through 6/30/22 [.068 x (1a) - ((1.068)^{½} - 1) x (1b)]	682,984
d)	Expected UAL before all other changes [(1a) - (1b) + (1c)]	10,219,264
e)	Change due to plan changes[1]	0
f)	Change due to AL Significant Increase	0
g)	Change due to assumption change	0
h)	Change due to method change	0
i)	Change due to discount rate change with Funding Risk Mitigation	0
j)	Expected UAL after all other changes [(1d) + (1e) + (1f) + (1g) + (1h) + (1i)]	10,219,264
k)	Actual UAL as of 6/30/22	49,999,717
l)	Total (Gain)/Loss for 2021-22 [(1k) - (1j)]	$39,780,453
2.	**Investment (Gain)/Loss for the Year**	
a)	Market Value of Assets as of 6/30/21	$239,427,253
b)	Prior fiscal year receivables	(11,824)
c)	Current fiscal year receivables	4,825
d)	Contributions received	20,321,746
e)	Benefits and refunds paid	(4,332,714)
f)	Transfers, SCP payments and interest, and miscellaneous adjustments	8,460
g)	Expected return at 6.8% per year	16,881,982
h)	Expected assets as of 6/30/22 [(2a) + (2b) + (2c) + (2d) + (2e) + (2f) + (2g)]	272,299,730
i)	Actual Market Value of Assets as of 6/30/22	236,700,002
j)	Investment (Gain)/Loss [(2h) - (2i)]	$35,599,727
3.	**Non-Investment (Gain)/Loss for the Year**	
a)	Total (Gain)/Loss (1l)	$39,780,453
b)	Investment (Gain)/Loss (2j)	35,599,727
c)	Non-Investment (Gain)/Loss [(3a) - (3b)]	$4,180,726

[1] Includes the effect, if any, of SB 1168, which increased the standard post-retirement lump sum death benefit from $500 to $2,000 for deaths occurring on or after July 1, 2023.

Back to Agenda Back to Item

Schedule of Amortization Bases

Below is the schedule of the plan's amortization bases. Note that there is a two-year lag between the valuation date and the start of the contribution year.

- The assets, liabilities, and funded status of the plan are measured as of the valuation date: June 30, 2022.
- The required employer contributions determined by the valuation are for the fiscal year beginning two years after the valuation date: FY 2024-25.

This two-year lag is necessary due to the amount of time needed to extract and test the membership and financial data, and the need to provide public agencies with their required employer contribution well in advance of the start of the fiscal year.

The Unfunded Accrued Liability (UAL) is used to determine the employer contribution and therefore must be rolled forward two years from the valuation date to the first day of the fiscal year for which the contribution is being determined. The UAL is rolled forward each year by subtracting the expected payment on the UAL for the fiscal year and adjusting for interest. The expected payment on the UAL for a fiscal year is equal to the Expected Employer Contribution for the fiscal year minus the Expected Normal Cost for the year. The Employer Contribution for the first fiscal year is determined by the actuarial valuation two years ago and the contribution for the second year is from the actuarial valuation one year ago. Additional discretionary payments are reflected in the Expected Payments column in the fiscal year they were made by the agency.

Reason for Base	Date Est.	Ramp Level 2024-25	Ramp Shape	Escalation Rate	Amort. Period	Balance 6/30/22	Expected Payment 2022-23	Balance 6/30/23	Expected Payment 2023-24	Balance 6/30/24	Minimum Required Payment 2024-25
FS Balance Payment With Opposite Sign	6/30/13	No Ramp		2.80%	21	5,529,818	375,452	5,517,838	375,873	5,504,608	386,397
(Gain)/Loss	6/30/14	100%	Up/Down	2.80%	22	(8,037,445)	(561,412)	(8,003,805)	(562,496)	(7,966,757)	(578,246)
Assumption Change	6/30/14	100%	Up/Down	2.80%	12	4,644,541	497,759	4,445,965	503,275	4,228,186	517,366
(Gain)/Loss	6/30/15	100%	Up/Down	2.80%	23	7,790,070	529,478	7,772,611	530,054	7,753,369	544,896
(Gain)/Loss	6/30/16	100%	Up/Down	2.80%	24	12,438,583	824,106	12,432,742	824,330	12,426,272	847,411
Assumption Change	6/30/16	100%	Up/Down	2.80%	14	3,578,091	340,899	3,469,102	344,028	3,349,468	353,661
(Gain)/Loss	6/30/17	100%	Up/Down	2.80%	25	(2,685,836)	(140,748)	(2,723,018)	(175,849)	(2,726,454)	(180,772)
Assumption Change	6/30/17	100%	Up/Down	2.80%	15	4,719,718	347,958	4,681,065	438,559	4,546,153	450,838
(Gain)/Loss	6/30/18	100%	Up/Down	2.80%	26	(2,297,715)	(90,468)	(2,360,466)	(120,438)	(2,396,512)	(154,763)
Assumption Change	6/30/18	100%	Up/Down	2.80%	16	5,320,555	290,229	5,382,418	389,745	5,345,644	500,822
Method Change	6/30/18	100%	Up/Down	2.80%	16	2,327,042	126,937	2,354,099	170,462	2,338,015	219,043
Investment (Gain)/Loss	6/30/19	80%	Up Only	0.00%	17	1,052,413	44,021	1,078,484	64,846	1,084,806	86,461
Non-Investment (Gain)/Loss	6/30/19	No Ramp		0.00%	17	(1,202,909)	(112,735)	(1,168,202)	(110,759)	(1,133,177)	(110,759)
Investment (Gain)/Loss	6/30/20	60%	Up Only	0.00%	18	4,839,119	106,001	5,058,633	207,946	5,187,720	311,920
Non-Investment (Gain)/Loss	6/30/20	No Ramp		0.00%	18	(1,314,298)	(120,158)	(1,279,494)	(117,998)	(1,244,556)	(117,999)
Assumption Change	6/30/21	No Ramp		0.00%	19	(741,217)	(270,989)	(511,569)	(46,002)	(498,815)	(46,002)
Net Investment (Gain)	6/30/21	40%	Up Only	0.00%	19	(22,262,687)	0	(23,776,550)	(511,070)	(24,865,195)	(1,022,139)
Non-Investment (Gain)/Loss	6/30/21	No Ramp		0.00%	19	(2,746,548)	0	(2,933,313)	(263,774)	(2,860,183)	(263,774)
Risk Mitigation	6/30/21	No Ramp		0.00%	0	8,708,006	(756,510)	10,081,959	10,419,108	0	0
Risk Mitigation Offset	6/30/21	No Ramp		0.00%	0	(9,440,037)	0	(10,081,959)	(10,419,108)	0	0

Schedule of Amortization Bases (continued)

Reason for Base	Date Est.	Ramp Level 2024-25	Ramp Shape	Escala-tion Rate	Amort. Period	Balance 6/30/22	Expected Payment 2022-23	Balance 6/30/23	Expected Payment 2023-24	Balance 6/30/24	Minimum Required Payment 2024-25
Investment (Gain)/Loss	6/30/22	20%	Up Only	0.00%	20	35,599,727	0	38,020,508	0	40,605,903	872,811
Non-Investment (Gain)/Loss	6/30/22	No Ramp		0.00%	20	4,180,726	0	4,465,015	0	4,768,636	428,813
Total						**49,999,717**	**1,429,820**	**51,922,063**	**1,940,732**	**53,447,131**	**3,045,985**

Amortization Schedule and Alternatives

The amortization schedule on the previous page shows the minimum contributions required according to the CalPERS amortization policy. Many agencies have expressed a desire for a more stable pattern of payments or have indicated interest in paying off the unfunded accrued liabilities more quickly than required. As such, we have provided alternative amortization schedules to help analyze the current amortization schedule and illustrate the potential savings of accelerating unfunded liability payments.

Shown on the following page are future year amortization payments based on 1) the current amortization schedule reflecting the individual bases and remaining periods shown on the previous page, and 2) alternative "fresh start" amortization schedules using two sample periods that would both result in interest savings relative to the current amortization schedule. To initiate a fresh start, please contact the plan actuary.

The current amortization schedule typically contains both positive and negative bases. Positive bases result from plan changes, assumption changes, method changes or plan experience that increase unfunded liability. Negative bases result from plan changes, assumption changes, method changes, or plan experience that decrease unfunded liability. The combination of positive and negative bases within an amortization schedule can result in unusual or problematic circumstances in future years, such as:

- When a negative payment would be required on a positive unfunded actuarial liability; or
- When the payment would completely amortize the total unfunded liability in a very short time period, and results in a large change in the employer contribution requirement.

In any year when one of the above scenarios occurs, the actuary will consider corrective action such as replacing the existing unfunded liability bases with a single "fresh start" base and amortizing it over an appropriate period.

The current amortization schedule on the following page may appear to show that, based on the current amortization bases, one of the above scenarios will occur at some point in the future. It is impossible to know today whether such a scenario will in fact arise since there will be additional bases added to the amortization schedule in each future year. Should such a scenario arise in any future year, the actuary will take appropriate action based on guidelines in the CalPERS amortization policy.

Amortization Schedule and Alternatives (continued)

	Current Amortization Schedule		Alternative Schedules			
			20 Year Amortization		15 Year Amortization	
Date	Balance	Payment	Balance	Payment	Balance	Payment
6/30/2024	53,447,131	3,045,985	53,447,131	4,806,156	53,447,131	5,606,800
6/30/2025	53,933,689	3,614,702	52,114,658	4,806,156	51,287,240	5,606,800
6/30/2026	53,865,600	4,164,082	50,691,577	4,806,156	48,980,476	5,606,800
6/30/2027	53,225,128	4,611,831	49,171,726	4,806,156	46,516,852	5,606,800
6/30/2028	52,078,384	5,573,057	47,548,525	4,806,156	43,885,702	5,606,800
6/30/2029	49,860,287	5,663,950	45,814,947	4,806,156	41,075,634	5,606,800
6/30/2030	47,397,429	5,757,386	43,963,485	4,806,156	38,074,481	5,606,800
6/30/2031	44,670,536	5,853,439	41,986,124	4,806,156	34,869,250	5,606,800
6/30/2032	41,658,950	5,823,125	39,874,302	4,806,156	31,446,063	5,606,801
6/30/2033	38,473,901	5,788,349	37,618,877	4,806,156	27,790,098	5,606,800
6/30/2034	35,108,210	5,655,661	35,210,083	4,806,156	23,885,528	5,606,800
6/30/2035	31,650,779	5,390,650	32,637,491	4,806,156	19,715,448	5,606,801
6/30/2036	28,232,113	4,907,650	29,889,962	4,806,156	15,261,801	5,606,800
6/30/2037	25,080,129	4,543,369	26,955,601	4,806,156	10,505,307	5,606,800
6/30/2038	22,090,275	4,156,658	23,821,704	4,806,156	5,425,372	5,606,801
6/30/2039	19,296,752	3,853,591	20,474,702	4,806,156		
6/30/2040	16,626,474	3,672,378	16,900,104	4,806,156		
6/30/2041	13,961,888	3,712,730	13,082,433	4,806,156		
6/30/2042	11,074,410	3,539,708	9,005,160	4,806,155		
6/30/2043	8,169,391	6,461,241	4,650,634	4,806,155		
6/30/2044	2,047,600	1,432,239				
6/30/2045	706,702	556,083				
6/30/2046	180,079	186,101				
6/30/2047						
6/30/2048						
6/30/2049						
Total	**97,963,965**		**96,123,118**		**84,102,003**	
Interest Paid	**44,516,834**		**42,675,987**		**30,654,872**	
Estimated Savings			**1,840,847**		**13,861,962**	

Reconciliation of Required Employer Contributions

Normal Cost (% of Payroll)

1. For Period 7/1/23 – 6/30/24	
a) Employer Normal Cost	9.17%
b) Employee contribution	7.53%
c) Total Normal Cost	16.70%
2. Changes since the prior year annual valuation	
a) Effect of demographic experience	0.03%
b) Effect of plan changes	0.00%
c) Effect of discount rate change due to Funding Risk Mitigation	0.00%
d) Effect of assumption changes	0.00%
e) Effect of method changes	0.00%
f) Net effect of the changes above [sum of (a) through (e)]	0.03%
3. For Period 7/1/24 – 6/30/25	
a) Employer Normal Cost	8.80%
b) Employee contribution	7.93%
c) Total Normal Cost	16.73%
Employer Normal Cost Change [(3a) – (1a)]	(0.37%)
Employee Contribution Change [(3b) – (1b)]	0.40%

Unfunded Liability Contribution ($)

1. For Period 7/1/23 – 6/30/24	1,940,732
2. Changes since the prior year annual valuation	
a) Effect of adjustments to prior year's amortization schedule	0
b) Effect of elimination of amortization bases	0
c) Effect of progression of amortization bases[1]	(196,371)
d) Effect of investment (gain)/loss during prior year[2]	872,811
e) Effect of non-investment (gain)/loss during prior year	428,813
f) Effect of re-amortizing existing bases due to Funding Risk Mitigation	0
g) Effect of Golden Handshake	0
h) Effect of plan changes	0
i) Effect of AL Significant Increase (Government Code section 20791)	0
j) Effect of assumption changes	0
k) Effect of adjustments to the amortization schedule (e.g., Fresh Start)	0
l) Effect of method change	0
m) Net effect of the changes above [sum of (a) through (l)]	1,105,253
3. For Period 7/1/24 – 6/30/25 [(1) + (2m)]	3,045,985

The amounts shown for the period 7/1/23 – 6/30/24 may be different if a prepayment of unfunded actuarial liability is made or a plan change became effective after the prior year's actuarial valuation was performed.

[1] Includes scheduled escalation in individual amortization base payments due to the 5-year ramp and payroll growth assumption used in the pre-2019 amortization policy.

[2] The unfunded liability contribution for the investment (gain)/loss during the year prior to the valuation date is 20% of the "full" annual requirement due to the 5-year ramp. Increases to this amount that occur during the ramp period will be included in line c) for each of the next four years.

Employer Contribution History

The table below provides a recent history of the required and discretionary employer contributions for the plan. The required amounts are based on the actuarial valuation from two years prior without subsequent adjustments, if any. Additional discretionary payments before July 1, 2018 or after June 30, 2023 are not included.

Fiscal Year	Employer Normal Cost	Unfunded Rate	Unfunded Liability Payment ($)	Additional Discretionary Payments
2015 - 16	8.309%	0.732%	N/A	N/A
2016 - 17	8.653%	0.535%	N/A	N/A
2017 - 18	8.313%	N/A	408,411	N/A
2018 - 19	8.504%	N/A	711,843	0
2019 - 20	8.614%	N/A	1,084,597	0
2020 - 21	8.636%	N/A	1,559,913	0
2021 - 22	8.52%	N/A	1,998,316	0
2022 - 23	8.41%	N/A	2,457,319	0
2023 - 24	9.17%	N/A	1,940,732	
2024 - 25	8.80%	N/A	3,045,985	

Funding History

The table below shows the recent history of actuarial accrued liability, market value of assets, unfunded accrued liability, funded ratio and annual covered payroll.

Valuation Date	Accrued Liability (AL)	Market Value of Assets (MVA)	Unfunded Accrued Liability (UAL)	Funded Ratio	Annual Covered Payroll
6/30/2013	$69,866,210	$65,270,419	$4,595,791	93.4%	$39,748,113
6/30/2014	85,156,272	82,507,208	2,649,064	96.9%	54,054,957
6/30/2015	98,869,903	89,826,375	9,043,528	90.9%	66,585,724
6/30/2016	118,014,125	96,830,795	21,183,330	82.1%	77,881,217
6/30/2017	140,710,502	117,116,358	23,594,144	83.2%	83,468,993
6/30/2018	167,369,342	138,194,748	29,174,594	82.6%	89,135,908
6/30/2019	191,025,200	160,092,031	30,933,169	83.8%	95,463,574
6/30/2020	216,506,069	181,074,132	35,431,937	83.6%	101,131,966
6/30/2021	249,962,336	239,427,253	10,535,083	95.8%	106,844,914
6/30/2022	286,699,719	236,700,002	49,999,717	82.6%	117,356,015

Normal Cost by Benefit Group

The table below displays the Total Normal Cost broken out by benefit group for FY 2024-25. The Total Normal Cost is the annual cost of service accrual for the fiscal year for active employees and can be viewed as the long-term contribution rate for the benefits contracted. Generally, the normal cost for a benefit group subject to more generous benefit provisions will exceed the normal cost for a group with less generous benefits. However, based on the characteristics of the members (particularly when the number of actives is small), this may not be the case. Future measurements of the Total Normal Cost for each group may differ significantly from the current values due to such factors as: changes in the demographics of the group, changes in economic and demographic assumptions, changes in plan benefits or applicable law.

Plan Identifier	Benefit Group Name	Total Normal Cost FY 2024-25	Number of Actives	Payroll on 6/30/2022
1936	Miscellaneous First Level	16.99%	297	$30,270,224
26435	Miscellaneous PEPRA Level	16.64%	1,146	$87,085,791
	Plan Total	**16.73%**	**1,443**	**$117,356,015**

Note that if a Benefit Group above has multiple bargaining units, each of which has separately contracted for different benefits such as Employer Paid Member Contributions, then the Normal Cost shown for the respective benefit level does not reflect those differences. Additionally, if a Second Level Benefit Group amended to the same benefit formula as a First Level Benefit Group, their Normal Costs may be dissimilar due to demographic or other population differences. For questions in these situations, please contact the plan actuary.

PEPRA Member Contribution Rates

The California Public Employees' Pension Reform Act of 2013 ("PEPRA") established new benefit formulas, final compensation period, and contribution requirements for "new" employees (generally those first hired into a CalPERS-covered position on or after January 1, 2013). In accordance with Government Code section 7522.30(b), "new members … shall have an initial contribution rate of at least 50% of the normal cost rate." The normal cost for the plan is dependent on the benefit levels, actuarial assumptions, and demographics of the plan, particularly members' entry age into the plan. Should the total normal cost of the plan change by more than 1% from the base total normal cost established for the plan, the new member rate shall be 50% of the new normal cost rounded to the nearest quarter percent.

The table below shows the determination of the PEPRA member contribution rates effective July 1, 2024, based on 50% of the total normal cost rate for each respective plan as of the June 30, 2022 valuation.

		Basis for Current Rate		Rates Effective July 1, 2024			
Plan Identifier	Benefit Group Name	Total Normal Cost	Member Rate	Total Normal Cost	Change	Change Needed	Member Rate
26435	Miscellaneous PEPRA Level	15.598%	7.75%	16.64%	1.042%	Yes	8.25%

For purposes of setting member rates, it is preferable to determine total normal cost using a large active population so that the rate remains relatively stable. While each CalPERS non-pooled plan has a sufficiently large active population for this purpose, the PEPRA active population by itself may not be sufficiently large. The total PEPRA normal cost will be determined based on the plan's PEPRA membership only if the number of members covered under the PEPRA formula meets either:

1. 50% of the active population, or
2. 25% of the active population and 100 or more PEPRA members

Until one of these conditions is met, the plan's total PEPRA normal cost will be determined using the entire active plan population (both PEPRA and Classic) based on the PEPRA benefit provisions. For this reason, the PEPRA member contribution rate determined in the table above may not equal 50% of the total normal cost of the PEPRA group shown on the "Normal Cost by Benefit Group" page.

Risk Analysis

- **Future Investment Return Scenarios**
- **Discount Rate Sensitivity**
- **Mortality Rate Sensitivity**
- **Maturity Measures**
- **Maturity Measures History**
- **Funded Status – Termination Basis**

Future Investment Return Scenarios

Analysis using the investment return scenarios from the Asset Liability Management process completed in 2021 was performed to determine the effects of various future investment returns on required employer contributions. The projections below reflect the impact of the CalPERS Funding Risk Mitigation policy. The projected normal cost rates reflect that the rates are anticipated to decline over time as new employees are hired into lower-cost benefit tiers. The projections also assume that all other actuarial assumptions will be realized and that no further changes in assumptions, contributions, benefits, or funding will occur.

The first table shows projected contribution requirements if the fund were to earn either 3.0% or 10.8% annually. These alternate investment returns were chosen because 90% of long-term average returns are expected to fall between them over the 20-year period ending June 30, 2042.

Assumed Annual Return FY 2022-23 through FY 2041-42	Projected Employer Contributions				
	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30
3.0% (5th percentile)					
Normal Cost Rate	8.8%	8.8%	8.7%	8.7%	8.7%
UAL Contribution	$3,843,000	$4,873,000	$6,078,000	$8,100,000	$9,586,000
10.8% (95th percentile)					
Normal Cost Rate	9.0%	9.2%	9.3%	9.5%	9.7%
UAL Contribution	$3,427,000	$3,580,000	$3,386,000	$3,406,000	$0

Required contributions outside of this range are also possible. In particular, whereas it is unlikely that investment returns will average less than 3.0% or greater than 10.8% over a 20-year period, the likelihood of a single investment return less than 3.0% or greater than 10.8% in any given year is much greater. The following analysis illustrates the effect of an extreme, single year investment return.

The portfolio has an expected volatility (or standard deviation) of 12.0% per year. Accordingly, in any given year there is a 16% probability that the annual return will be -5.2% or less and a 2.5% probability that the annual return will be -17.2% or less. These returns represent one and two standard deviations below the expected return of 6.8%.

The following table shows the effect of a one or two standard deviation investment loss in FY 2022-23 on the FY 2025-26 contribution requirements. Note that a single-year investment gain or loss decreases or increases the required UAL contribution amount incrementally for each of the next five years, not just one, due to the 5-year ramp in the amortization policy. However, the contribution requirements beyond the first year are also impacted by investment returns beyond the first year. Historically, significant downturns in the market are often followed by higher than average returns. Such investment gains would offset the impact of these single year negative returns in years beyond FY 2025-26.

Assumed Annual Return for Fiscal Year 2022-23	Required Employer Contributions	Projected Employer Contributions
	FY 2024-25	FY 2025-26
(17.2%) (2 standard deviation loss)		
Normal Cost Rate	8.80%	8.8%
UAL Contribution	$3,045,985	$5,060,000
(5.2%) (1 standard deviation loss)		
Normal Cost Rate	8.80%	8.8%
UAL Contribution	$3,045,985	$4,336,000

- Without investment gains (returns higher than 6.8%) in year FY 2023-24 or later, projected contributions rates would continue to rise over the next four years due to the continued phase-in of the impact of the illustrated investment loss in FY 2022-23.
- The Pension Outlook Tool can be used to model projected contributions for these scenarios beyond FY 2025-26 as well as to model other investment return scenarios.

Back to Agenda Back to Item

Discount Rate Sensitivity

The discount rate assumption is calculated as the sum of the assumed real rate of return and the assumed annual price inflation, currently 4.5% and 2.3%, respectively. Changing either the price inflation assumption or the real rate of return assumption will change the discount rate. The sensitivity of the valuation results to the discount rate assumption depends on which component of the discount rate is changed. Shown below are various valuation results as of June 30, 2022 assuming alternate discount rates by changing the two components independently. Results are shown using the current discount rate of 6.8% as well as alternate discount rates of 5.8% and 7.8%. The rates of 5.8% and 7.8% were selected since they illustrate the impact of a 1.0% increase or decrease to the 6.8% assumption.

Sensitivity to the Real Rate of Return Assumption

As of June 30, 2022	1% Lower Real Return Rate	Current Assumptions	1% Higher Real Return Rate
Discount Rate	**5.8%**	**6.8%**	**7.8%**
Price Inflation	2.3%	2.3%	2.3%
Real Rate of Return	**3.5%**	**4.5%**	**5.5%**
a) Total Normal Cost	20.86%	16.73%	13.59%
b) Accrued Liability	$336,242,776	$286,699,719	$246,866,431
c) Market Value of Assets	$236,700,002	$236,700,002	$236,700,002
d) Unfunded Liability/(Surplus) [(b) - (c)]	$99,542,774	$49,999,717	$10,166,429
e) Funded Ratio	70.4%	82.6%	95.9%

Sensitivity to the Price Inflation Assumption

As of June 30, 2022	1% Lower Inflation Rate	Current Assumptions	1% Higher Inflation Rate
Discount Rate	**5.8%**	**6.8%**	**7.8%**
Price Inflation	**1.3%**	**2.3%**	**3.3%**
Real Rate of Return	4.5%	4.5%	4.5%
a) Total Normal Cost	17.21%	16.73%	15.88%
b) Accrued Liability	$292,292,403	$286,699,719	$274,204,616
c) Market Value of Assets	$236,700,002	$236,700,002	$236,700,002
d) Unfunded Liability/(Surplus) [(b) - (c)]	$55,592,401	$49,999,717	$37,504,614
e) Funded Ratio	81.0%	82.6%	86.3%

Mortality Rate Sensitivity

The following table looks at the change in the June 30, 2022 plan costs and funded status under two different longevity scenarios, namely assuming rates of post-retirement mortality are 10% lower or 10% higher than our current mortality assumptions adopted in 2021. This type of analysis highlights the impact on the plan of a change in the mortality assumption.

As of June 30, 2022	10% Lower Mortality Rates	Current Assumptions	10% Higher Mortality Rates
a) Total Normal Cost	17.04%	16.73%	16.44%
b) Accrued Liability	$292,531,284	$286,699,719	$281,338,152
c) Market Value of Assets	$236,700,002	$236,700,002	$236,700,002
d) Unfunded Liability/(Surplus) [(b) - (c)]	$55,831,282	$49,999,717	$44,638,150
e) Funded Ratio	80.9%	82.6%	84.1%

Maturity Measures

As pension plans mature they become more sensitive to risks. Understanding plan maturity and how it affects the ability of a pension plan sponsor to tolerate risk is important in understanding how the pension plan is impacted by investment return volatility, other economic variables and changes in longevity or other demographic assumptions. One way to look at the maturity level of CalPERS and its plans is to look at the ratio of a plan's retiree liability to its total liability. A pension plan in its infancy will have a very low ratio of retiree liability to total liability. As the plan matures, the ratio increases. A mature plan will often have a ratio above 60%-65%.

Ratio of Retiree Accrued Liability to Total Accrued Liability	**June 30, 2021**	**June 30, 2022**
1. Retiree Accrued Liability	42,828,354	51,729,916
2. Total Accrued Liability	249,962,336	286,699,719
3. Ratio of Retiree AL to Total AL [(1) / (2)]	17%	18%

Another measure of the maturity level of CalPERS and its plans is the ratio of actives to retirees, also called the support ratio. A pension plan in its infancy will have a very high ratio of active to retired members. As the plan matures and members retire, the ratio declines. A mature plan will often have a ratio near or below one.

To calculate the support ratio for the rate plan, retirees and beneficiaries receiving a continuance are each counted as one, even though they may have only worked a portion of their careers as an active member of this rate plan. For this reason, the support ratio, while intuitive, may be less informative than the ratio of retiree liability to total accrued liability above. For comparison, the support ratio for all CalPERS public agency plans is 0.82 and is calculated consistently with how it is for the individual rate plan. Note that to calculate the support ratio for all public agency plans, a retiree with service from more than one CalPERS agency is counted as a retiree more than once.

Support Ratio	**June 30, 2021**	**June 30, 2022**
1. Number of Actives	1,377	1,443
2. Number of Retirees	180	203
3. Support Ratio [(1) / (2)]	7.65	7.11

The actuarial calculations supplied in this communication are based on various assumptions about long-term demographic and economic behavior. Unless these assumptions (e.g., terminations, deaths, disabilities, retirements, salary growth, investment return) are exactly realized each year, there will be differences on a year-to-year basis. The year-to-year differences between actual experience and the assumptions are called actuarial gains and losses and serve to lower or raise required employer contributions from one year to the next. Therefore, employer contributions will inevitably fluctuate, especially due to the ups and downs of investment returns.

Maturity Measures (continued)

Asset Volatility Ratio

Shown in the table below is the asset volatility ratio (AVR), which is the ratio of market value of assets to payroll. Plans that have a higher AVR experience more volatile employer contributions (as a percentage of payroll) due to investment return. For example, a plan with AVR of 8 may experience twice the contribution volatility due to investment return volatility than a plan with AVR of 4. It should be noted that this ratio is a measure of the current situation. It increases over time but generally tends to stabilize as a plan matures.

Liability Volatility Ratio

Also shown in the table below is the liability volatility ratio (LVR), which is the ratio of accrued liability to payroll. Plans that have a higher LVR experience more volatile employer contributions (as a percentage of payroll) due to changes in liability. For example, a plan with LVR of 8 is expected to have twice the contribution volatility of a plan with LVR of 4 when there is a change in accrued liability, such as when there is a change in actuarial assumptions. It should be noted that this ratio indicates a longer-term potential for contribution volatility, since the AVR, described above, will tend to move closer to the LVR as the funded ratio approaches 100%.

Contribution Volatility	June 30, 2021	June 30, 2022
1. Market Value of Assets without Receivables	$239,415,430	$236,695,177
2. Payroll	106,844,914	117,356,015
3. Asset Volatility Ratio (AVR) [(1) / (2)]	2.2	2.0
4. Accrued Liability	$249,962,336	$286,699,719
5. Liability Volatility Ratio (LVR) [(4) / (2)]	2.3	2.4

Maturity Measures History

Valuation Date	Ratio of Retiree Accrued Liability to Total Accrued Liability	Support Ratio	Asset Volatility Ratio	Liability Volatility Ratio
6/30/2017	19%	9.48	1.4	1.7
6/30/2018	18%	8.66	1.5	1.9
6/30/2019	19%	8.22	1.7	2.0
6/30/2020	18%	7.95	1.8	2.1
6/30/2021	17%	7.65	2.2	2.3
6/30/2022	18%	7.11	2.0	2.4

Funded Status – Termination Basis

The funded status measured on a termination basis is an estimate of the financial position of the plan had the contract with CalPERS been terminated as of June 30, 2022. The accrued liability on a termination basis (termination liability) is calculated differently from the plan's ongoing funding liability. For the termination liability calculation, both compensation and service are frozen as of the valuation date and no future pay increases or service accruals are assumed. This measure of funded status is not appropriate for assessing the need for future employer contributions in the case of an ongoing plan, that is, for an employer that continues to provide CalPERS retirement benefits to active employees. Unlike the actuarial cost method used for ongoing plans, the termination liability is the present value of the benefits earned through the valuation date.

A more conservative investment policy and asset allocation strategy was adopted by the board for the Terminated Agency Pool. The Terminated Agency Pool has limited funding sources since no future employer contributions will be made. Therefore, expected benefit payments are secured by risk-free assets and benefit security for members is increased while limiting the funding risk. However, this asset allocation has a lower expected rate of return than the remainder of the PERF and consequently, a lower discount rate assumption. The lower discount rate for the Terminated Agency Pool results in higher liabilities for terminated plans.

The effective termination discount rate will depend on actual market rates of return for risk-free securities on the date of termination. As market discount rates are variable, the table below shows a range for the termination liability based on the lowest and highest interest rates observed during an approximate 19-month period from 12 months before the valuation date to seven months after.

	Discount Rate: 1.75% Price Inflation: 2.50%			**Discount Rate: 4.50% Price Inflation: 2.75%**		
Market Value of Assets (MVA)	**Termination Liability[1,2]**	**Funded Ratio**	**Unfunded Termination Liability**	**Termination Liability[1,2]**	**Funded Ratio**	**Unfunded Termination Liability**
$236,700,002	$641,709,319	36.9%	$405,009,317	$380,724,438	62.2%	$144,024,436

[1] The termination liabilities calculated above include a 5% contingency load. The contingency load and other actuarial assumptions can be found in Appendix A.

[2] The discount rate used for termination valuations is a weighted average of the 10-year and 30-year U.S. Treasury yields where the weights are based on matching asset and liability durations as of the termination date. The discount rates used in the table are based on 20-year Treasury bonds, rounded to the nearest quarter percentage point, which is a good proxy for most plans. The 20-year Treasury yield was 3.38% on June 30, 2022, the valuation date.

In order to terminate the plan, first contact our Pension Contract Services unit to initiate a Resolution of Intent to Terminate. The completed Resolution will allow the plan actuary to provide a preliminary termination valuation with a more up-to-date estimate of the plan liabilities. Before beginning this process, please consult with the plan actuary.

Plan’s Major Benefit Provisions

Plan's Major Benefit Options

Shown below is a summary of the major optional benefits for which the agency has contracted. A description of principal standard and optional plan provisions is in Appendix B.

	Benefit Group		
Member Category	Misc	Misc	
Demographics			
Actives	Yes	Yes	
Transfers/Separated	Yes	Yes	
Receiving	Yes	Yes	
Benefit Provision			
Benefit Formula	2% @ 60	2% @ 62	
Social Security Coverage	No	No	
Full/Modified	Full	Full	
Employee Contribution Rate	7.00%	7.75%	
Final Average Compensation Period	Three Year	Three Year	
Sick Leave Credit	No	No	
Non-Industrial Disability	Standard	Standard	
Industrial Disability	No	No	
Pre-Retirement Death Benefits			
Optional Settlement 2	No	No	
1959 Survivor Benefit Level	Level 3	Level 3	
Special	No	No	
Alternate (firefighters)	No	No	
Post-Retirement Death Benefits			
Lump Sum	$5000	$5000	
Survivor Allowance (PRSA)	No	No	
COLA	3%	3%	

Appendices

- **Appendix A – Actuarial Methods and Assumptions**
- **Appendix B – Principal Plan Provisions**
- **Appendix C – Participant Data**
- **Appendix D – Glossary**

Appendix A

Actuarial Methods and Assumptions

- **Actuarial Data**
- **Actuarial Methods**
- **Actuarial Assumptions**
- **Miscellaneous**

Actuarial Data

As stated in the Actuarial Certification, the data which serves as the basis of this valuation has been obtained from the various CalPERS databases. We have reviewed the valuation data and believe that it is reasonable and appropriate in aggregate. We are unaware of any potential data issues that would have a material effect on the results of this valuation, except that data does not always contain the latest salary information for former members now in reciprocal systems and does not recognize the potential for unusually large salary deviation in certain cases such as elected officials. Therefore, salary information in these cases may not be accurate. These situations are relatively infrequent, however, and generally do not have a material impact on the required employer contributions.

Actuarial Methods

Actuarial Cost Method

The actuarial cost method used is the Entry Age Actuarial Cost Method. Under this method, projected benefits are determined for all members and the associated liabilities are spread in a manner that produces level annual cost as a percentage of pay in each year from the member's entry age to their assumed retirement age on the valuation date. The cost allocated to the current fiscal year is called the normal cost.

The actuarial accrued liability for active members is then calculated as the portion of the total cost of the plan allocated to prior years. The actuarial accrued liability for members currently receiving benefits and for members entitled to deferred benefits is equal to the present value of the benefits expected to be paid. No normal costs are applicable for these participants.

CalPERS uses an in-house proprietary actuarial model for calculating plan costs. We believe this model is fit for its intended purpose and meets all applicable Actuarial Standards of Practice. Furthermore, the actuarial results of our model are independently confirmed periodically by outside auditing actuaries. The actuarial assumptions used are internally consistent and the generated results are reasonable.

Amortization of Unfunded Actuarial Accrued Liability

The excess of the total actuarial accrued liability over the market value of plan assets is called the unfunded actuarial accrued liability (UAL). Funding requirements are determined by adding the normal cost and a payment toward the UAL. The UAL payment is equal to the sum of individual amortization payments, each representing a different source of UAL for a given measurement period.

Amortization payments are determined according to the CalPERS amortization policy. The board adopted a new policy effective for the June 30, 2019 actuarial valuation. The new policy applies prospectively only; amortization bases (sources of UAL) established prior to the June 30, 2019 valuation will continue to be amortized according to the prior policy.

Prior Policy (Bases Established prior to June 30, 2019)

Amortization payments are determined as a level percentage of payroll whereby the payment increases each year at an escalation rate. Gains or losses are amortized over a fixed 30-year period with a 5-year ramp up at the beginning and a 5-year ramp down at the end of the amortization period. All changes in liability due to plan amendments (other than golden handshakes) are amortized over a 20-year period with no ramp. Changes in actuarial assumptions or changes in actuarial methodology are amortized over a 20-year period with a 5-year ramp up at the beginning and a 5-year ramp down at the end of the amortization period. Changes in unfunded accrued liability due to a Golden Handshake will be amortized over a period of five years. Bases established prior to June 30, 2013 may be amortized differently. A summary is provided in the following table:

Back to Agenda Back to Item

Driver	Source				
	(Gain)/Loss				
	Investment	Non-investment	Assumption/Method Change	Benefit Change	Golden Handshake
Amortization Period	30 Years	30 Years	20 Years	20 Years	5 Years
Escalation Rate - Active Plans - Inactive Plans	2.80% 0%	2.80% 0%	2.80% 0%	2.80% 0%	2.80% 0%
Ramp Up	5	5	5	0	0
Ramp Down	5	5	5	0	0

The 5-year ramp up means that the payments in the first four years of the amortization period are 20%, 40%, 60% and 80% of the "full" payment which begins in year five. The 5-year ramp down means that the reverse is true in the final four years of the amortization period.

Current Policy (Bases Established on or after June 30, 2019)

Amortization payments are determined as a level dollar amount. Investment gains or losses are amortized over a fixed 20-year period with a 5-year ramp up at the beginning of the amortization period. Non-investment gains or losses are amortized over a fixed 20-year period with no ramps. All changes in liability due to plan amendments (other than golden handshakes) are amortized over a 20-year period with no ramps. Changes in actuarial assumptions or changes in actuarial methodology are amortized over a 20-year period with no ramps. Changes in unfunded accrued liability due to a Golden Handshake are amortized over a period of five years. A summary is provided in the table below:

	Source				
	(Gain)/Loss				
	Investment	Non-investment	Assumption/ Method Change	Benefit Change	Golden Handshake
Amortization Period	20 Years	20 Years	20 Years	20 Years	5 Years
Escalation Rate	0%	0%	0%	0%	0%
Ramp Up	5	0	0	0	0
Ramp Down	0	0	0	0	0

Exceptions for Inconsistencies

An exception to the amortization rules above is used whenever their application results in inconsistencies. In these cases, a "fresh start" approach is used. This means that the current unfunded actuarial liability is projected and amortized over a set number of years. For example, a fresh start is needed in the following situations:

- When a negative payment would be required on a positive unfunded actuarial liability; or
- When the payment would completely amortize the total unfunded liability in a very short time period, and results in a large change in the employer contribution requirement.

It should be noted that the actuary may determine that a fresh start is necessary under other circumstances. In all cases of a fresh start, the period is set by the actuary at what is deemed appropriate; however, the period will not be greater than 20 years.

Exceptions for Plans in Surplus

If a surplus exists (i.e., the Market Value of Assets exceeds the plan's accrued liability) any prior amortization layers shall be considered fully amortized, and the surplus shall not be amortized.

In the event of any subsequent unfunded liability, a Fresh Start shall be used with an amortization period of 20 years or less.

Exceptions for Small Amounts

Where small unfunded liabilities are identified in annual valuations which result in small payment amounts, the actuary may shorten the remaining period for these bases.

- When the balance of a single amortization base has an absolute value less than $250, the amortization period is reduced to one year.
- When the entire unfunded liability is a small amount, the actuary may perform a Fresh Start and use an appropriate amortization period.

Exceptions for Inactive Plans

The following exceptions apply to plans classified as Inactive. These plans have no active members and no expectation to have active members in the future.

- Amortization of the unfunded liability is on a "level dollar" basis rather than a "level percent of pay" basis. For amortization layers, which utilize a ramp up and ramp down, the "ultimate" payment is constant.
- Actuarial judgment will be used to shorten amortization periods for Inactive plans with existing periods that are deemed too long given the duration of the liability. The specific demographics of the plan will be used to determine if shorter periods may be more appropriate.

Exceptions for Inactive Agencies

For a public agency with no active members in any CalPERS rate plan, the unfunded liability shall be amortized over a closed amortization period of no more than 15 years.

Asset Valuation Method

The Actuarial Value of Assets is set equal to the market value of assets. Asset values include accounts receivable.

PEPRA Normal Cost Rate Methodology

Per Government Code section 7522.30(b), the "normal cost rate" shall mean the annual actuarially determined normal cost for the plan of retirement benefits provided to the new member and shall be established based on actuarial assumptions used to determine the liabilities and costs as part of the annual actuarial valuation. The plan of retirement benefits shall include any elements that would impact the actuarial determination of the normal cost, including, but not limited to, the retirement formula, eligibility and vesting criteria, ancillary benefit provisions, and any automatic cost-of-living adjustments as determined by the public retirement system.

For purposes of setting member rates, it is preferable to determine total normal cost using a large active population so that the rate remains relatively stable. While each CalPERS non-pooled plan has a sufficiently large active population for this purpose, the PEPRA active population by itself may not be sufficiently large. The total PEPRA normal cost will be determined based on the plan's PEPRA membership only if the number of members covered under the PEPRA formula meets either:

1. 50% of the active population, or
2. 25% of the active population and 100 or more PEPRA members

Until one of these conditions is met, the plan's total PEPRA normal cost will be determined using the entire active plan population (both PEPRA and Classic) based on the PEPRA benefit provisions.

Back to Agenda Back to Item

Actuarial Assumptions

In 2021, CalPERS completed its most recent asset liability management study incorporating actuarial assumptions and strategic asset allocation. In November 2021, the board adopted changes to the asset allocation that increased the expected volatility of returns. The adopted asset allocation was expected to have a long-term blended return that continued to support a discount rate assumption of 6.80%. The board also approved several changes to the demographic assumptions that more closely aligned with actual experience.

For more details and additional rationale for the selection of the actuarial assumptions, please refer to the CalPERS Experience Study and Review of Actuarial Assumptions report from November 2021 that can be found on the CalPERS website under: Forms and Publications. Click on "View All" and search for Experience Study.

All actuarial assumptions (except the discount rates used for the accrued liability on a termination basis) represent an estimate of future experience rather than observations of the estimates inherent in market data.

Economic Assumptions

Discount Rate

The prescribed discount rate assumption, adopted by the board on November 17, 2021, is 6.80% compounded annually (net of investment and administrative expenses) as of June 30, 2022.

Termination Liability Discount Rate

The current discount rate assumption used for termination valuations is a weighted average of the 10-year and 30-year U.S. Treasury yields where the weights are based on matching asset and liability durations as of the termination date.

The accrued liabilities on a termination basis in this report are calculated using an observed range of market interest rates. This range is based on the lowest and highest 20-year Treasury bond observed during an approximate 19-month period from 12 months before the valuation date to seven months after. The 20-year Treasury bond has a similar duration to most plan liabilities and serves as a good proxy for the termination discount rate. The 20-year Treasury yield was 3.38% on June 30, 2022.

Salary Growth

Annual increases vary by category, entry age, and duration of service. A sample of assumed increases are shown below. Wage inflation assumption in the valuation year (2.80% for 2022) is added to these factors for total salary growth.

Public Agency Miscellaneous

Duration of Service	(Entry Age 20)	(Entry Age 30)	(Entry Age 40)
0	0.0764	0.0621	0.0521
1	0.0663	0.0528	0.0424
2	0.0576	0.0449	0.0346
3	0.0501	0.0381	0.0282
4	0.0435	0.0324	0.0229
5	0.0378	0.0276	0.0187
10	0.0201	0.0126	0.0108
15	0.0155	0.0102	0.0071
20	0.0119	0.0083	0.0047
25	0.0091	0.0067	0.0031
30	0.0070	0.0054	0.0020

Public Agency Fire

Duration of Service	(Entry Age 20)	(Entry Age 30)	(Entry Age 40)
0	0.1517	0.1549	0.0631
1	0.1191	0.1138	0.0517
2	0.0936	0.0835	0.0423
3	0.0735	0.0613	0.0346
4	0.0577	0.0451	0.0284
5	0.0453	0.0331	0.0232
10	0.0188	0.0143	0.0077
15	0.0165	0.0124	0.0088
20	0.0145	0.0108	0.0101
25	0.0127	0.0094	0.0115
30	0.0112	0.0082	0.0132

Public Agency Police

Duration of Service	(Entry Age 20)	(Entry Age 30)	(Entry Age 40)
0	0.1181	0.1051	0.0653
1	0.0934	0.0812	0.0532
2	0.0738	0.0628	0.0434
3	0.0584	0.0485	0.0353
4	0.0462	0.0375	0.0288
5	0.0365	0.0290	0.0235
10	0.0185	0.0155	0.0118
15	0.0183	0.0150	0.0131
20	0.0181	0.0145	0.0145
25	0.0179	0.0141	0.0161
30	0.0178	0.0136	0.0179

Salary Growth (continued)

Public Agency County Peace Officers

Duration of Service	(Entry Age 20)	(Entry Age 30)	(Entry Age 40)
0	0.1238	0.1053	0.0890
1	0.0941	0.0805	0.0674
2	0.0715	0.0616	0.0510
3	0.0544	0.0471	0.0387
4	0.0413	0.0360	0.0293
5	0.0314	0.0276	0.0222
10	0.0184	0.0142	0.0072
15	0.0174	0.0124	0.0073
20	0.0164	0.0108	0.0074
25	0.0155	0.0094	0.0075
30	0.0147	0.0083	0.0077

Schools

Duration of Service	(Entry Age 20)	(Entry Age 30)	(Entry Age 40)
0	0.0275	0.0275	0.0200
1	0.0422	0.0373	0.0298
2	0.0422	0.0373	0.0298
3	0.0422	0.0373	0.0298
4	0.0388	0.0314	0.0245
5	0.0308	0.0239	0.0179
10	0.0236	0.0160	0.0121
15	0.0182	0.0135	0.0103
20	0.0145	0.0109	0.0085
25	0.0124	0.0102	0.0058
30	0.0075	0.0053	0.0019

- The Miscellaneous salary scale is used for Local Prosecutors.
- The Police salary scale is used for Other Safety, Local Sheriff, and School Police.

Price Inflation

2.30% compounded annually.

Wage Inflation

2.80% compounded annually (used in projecting individual salary increases).

Payroll Growth

2.80% compounded annually (used in projecting the payroll over which the unfunded liability is amortized for level percent of payroll bases). This assumption is used for all plans with active members.

Non-valued Potential Additional Liabilities

The potential liability loss for a cost-of-living increase exceeding the 2.30% price inflation assumption and any potential liability loss from future member service purchases that are not reflected in the valuation.

Miscellaneous Loading Factors

Credit for Unused Sick Leave

Total years of service is increased by 1% for those plans that have adopted the provision of providing Credit for Unused Sick Leave.

Back to Agenda Back to Item

Conversion of Employer Paid Member Contributions (EPMC)

Total years of service is increased by the Employee Contribution Rate for those plans with the provision providing for the Conversion of Employer Paid Member Contributions (EPMC) during the final compensation period.

Norris Decision (Best Factors)

Employees hired prior to July 1, 1982 have projected benefit amounts increased in order to reflect the use of "Best Factors" in the calculation of optional benefit forms. This is due to a 1983 Supreme Court decision, known as the Norris decision, which required males and females to be treated equally in the determination of benefit amounts. Consequently, anyone already employed at that time is given the best possible conversion factor when optional benefits are determined. No loading is necessary for employees hired after July 1, 1982.

Termination Liability

The termination liabilities include a 5% contingency load. This load is for unforeseen improvements in mortality.

Demographic Assumptions

Pre-Retirement Mortality

The mortality assumptions are based on mortality rates resulting from the most recent CalPERS Experience Study adopted by the CalPERS Board in November 2021. For purposes of the mortality rates, the rates incorporate generational mortality to capture on-going mortality improvement. Generational mortality explicitly assumes that members born more recently will live longer than the members born before them thereby capturing the mortality improvement seen in the past and expected continued improvement. For more details, please refer to the 2021 experience study report that can be found on the CalPERS website.

Rates vary by age and gender are shown in the table below. This table only contains a sample of the 2017 base table rates for illustrative purposes. The non-industrial death rates are used for all plans. The industrial death rates are used for Safety plans (except for local Safety members described in Section 20423.6 where the agency has not specifically contracted for industrial death benefits.)

	Miscellaneous		Safety			
	Non-Industrial Death (Not Job-Related)		Non-Industrial Death (Not Job-Related)		Industrial Death (Job-Related)	
Age	Male	Female	Male	Female	Male	Female
20	0.00039	0.00014	0.00038	0.00014	0.00004	0.00002
25	0.00033	0.00013	0.00034	0.00018	0.00004	0.00002
30	0.00044	0.00019	0.00042	0.00025	0.00005	0.00003
35	0.00058	0.00029	0.00048	0.00034	0.00005	0.00004
40	0.00075	0.00039	0.00055	0.00042	0.00006	0.00005
45	0.00093	0.00054	0.00066	0.00053	0.00007	0.00006
50	0.00134	0.00081	0.00092	0.00073	0.00010	0.00008
55	0.00198	0.00123	0.00138	0.00106	0.00015	0.00012
60	0.00287	0.00179	0.00221	0.00151	0.00025	0.00017
65	0.00403	0.00250	0.00346	0.00194	0.00038	0.00022
70	0.00594	0.00404	0.00606	0.00358	0.00067	0.00040
75	0.00933	0.00688	0.01099	0.00699	0.00122	0.00078
80	0.01515	0.01149	0.02027	0.01410	0.00225	0.00157

- The pre-retirement mortality rates above are for 2017 and are projected generationally for future years using 80% of the Society of Actuaries' Scale MP-2020.
- Miscellaneous plans usually have industrial death rates set to zero unless the agency has specifically contracted for industrial death benefits. If so, each non-industrial death rate shown above will be split into two components: 99% will become the non-industrial death rate and 1% will become the industrial death rate.

Back to Agenda Back to Item

Post-Retirement Mortality

Rates vary by age, type of retirement, and gender. See sample rates in table below. These rates are used for all plans.

	Service Retirement		Non-Industrial Disability (Not Job-Related)		Industrial Disability (Job-Related)	
Age	Male	Female	Male	Female	Male	Female
50	0.00267	0.00199	0.01701	0.01439	0.00430	0.00311
55	0.00390	0.00325	0.02210	0.01734	0.00621	0.00550
60	0.00578	0.00455	0.02708	0.01962	0.00944	0.00868
65	0.00857	0.00612	0.03334	0.02276	0.01394	0.01190
70	0.01333	0.00996	0.04001	0.02910	0.02163	0.01858
75	0.02391	0.01783	0.05376	0.04160	0.03446	0.03134
80	0.04371	0.03403	0.07936	0.06112	0.05853	0.05183
85	0.08274	0.06166	0.11561	0.09385	0.10137	0.08045
90	0.14539	0.11086	0.16608	0.14396	0.16584	0.12434
95	0.24665	0.20364	0.24665	0.20364	0.24665	0.20364
100	0.36198	0.31582	0.36198	0.31582	0.36198	0.31582
105	0.52229	0.44679	0.52229	0.44679	0.52229	0.44679
110	1.00000	1.00000	1.00000	1.00000	1.00000	1.00000

The post-retirement mortality rates above are for 2017 and are projected generationally for future years using 80% of the Society of Actuaries' Scale MP-2020.

Marital Status

For active members, a percentage who are married upon retirement is assumed according to the member category as shown in the following table.

Member Category	Percent Married
Miscellaneous Member	70%
Local Police	85%
Local Fire	85%
Other Local Safety	70%
School Police	85%
Local County Peace Officers	75%

Age of Spouse

It is assumed that female spouses are 3 years younger than male spouses. This assumption is used for all plans.

Separated Members

It is assumed that separated members refund immediately if non-vested. Separated members who are vested are assumed to retire at age 59 for Miscellaneous members and age 54 for Safety members.

Termination with Refund

Rates vary by entry age and service for Miscellaneous plans. Rates vary by service for Safety plans. See sample rates in tables below.

Public Agency Miscellaneous

Duration of Service	Entry Age 20		Entry Age 25		Entry Age 30		Entry Age 35		Entry Age 40		Entry Age 45	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0	0.1851	0.1944	0.1769	0.1899	0.1631	0.1824	0.1493	0.1749	0.1490	0.1731	0.1487	0.1713
1	0.1531	0.1673	0.1432	0.1602	0.1266	0.1484	0.1101	0.1366	0.1069	0.1323	0.1037	0.1280
2	0.1218	0.1381	0.1125	0.1307	0.0970	0.1183	0.0815	0.1058	0.0771	0.0998	0.0726	0.0938
3	0.0927	0.1085	0.0852	0.1020	0.0727	0.0912	0.0601	0.0804	0.0556	0.0737	0.0511	0.0669
4	0.0672	0.0801	0.0616	0.0752	0.0524	0.0670	0.0431	0.0587	0.0392	0.0523	0.0352	0.0459
5	0.0463	0.0551	0.0423	0.0517	0.0358	0.0461	0.0292	0.0404	0.0261	0.0350	0.0230	0.0296
10	0.0112	0.0140	0.0101	0.0129	0.0083	0.0112	0.0064	0.0094	0.0048	0.0071	0.0033	0.0049
15	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
20	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
25	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
30	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
35	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000

Public Agency Safety

Duration of Service	Fire		Police		County Peace Officer	
	Male	Female	Male	Female	Male	Female
0	0.1022	0.1317	0.1298	0.1389	0.1086	0.1284
1	0.0686	0.1007	0.0789	0.0904	0.0777	0.0998
2	0.0441	0.0743	0.0464	0.0566	0.0549	0.0759
3	0.0272	0.0524	0.0274	0.0343	0.0385	0.0562
4	0.0161	0.0349	0.0170	0.0206	0.0268	0.0402
5	0.0092	0.0214	0.0113	0.0128	0.0186	0.0276
10	0.0015	0.0000	0.0032	0.0047	0.0046	0.0038
15	0.0000	0.0000	0.0000	0.0000	0.0023	0.0036
20	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
25	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
30	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
35	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000

- The police termination and refund rates are also used for Public Agency Local Prosecutors, Other Safety, Local Sheriff, and School Police.

Termination with Refund (continued)

Schools

Duration of Service	Entry Age 20		Entry Age 25		Entry Age 30		Entry Age 35		Entry Age 40		Entry Age 45	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0	0.2054	0.2120	0.1933	0.1952	0.1730	0.1672	0.1527	0.1392	0.1423	0.1212	0.1318	0.1032
1	0.1922	0.2069	0.1778	0.1883	0.1539	0.1573	0.1300	0.1264	0.1191	0.1087	0.1083	0.0910
2	0.1678	0.1859	0.1536	0.1681	0.1298	0.1383	0.1060	0.1086	0.0957	0.0934	0.0853	0.0782
3	0.1384	0.1575	0.1256	0.1417	0.1042	0.1155	0.0829	0.0893	0.0736	0.0774	0.0643	0.0656
4	0.1085	0.1274	0.0978	0.1143	0.0800	0.0925	0.0622	0.0707	0.0542	0.0620	0.0462	0.0533
5	0.0816	0.0991	0.0732	0.0887	0.0590	0.0713	0.0449	0.0539	0.0383	0.0476	0.0317	0.0413
10	0.0222	0.0248	0.0200	0.0221	0.0163	0.0174	0.0125	0.0128	0.0094	0.0100	0.0063	0.0072
15	0.0106	0.0132	0.0095	0.0113	0.0077	0.0083	0.0058	0.0052	0.0040	0.0039	0.0021	0.0026
20	0.0059	0.0065	0.0050	0.0054	0.0035	0.0036	0.0021	0.0019	0.0010	0.0009	0.0000	0.0000
25	0.0029	0.0034	0.0025	0.0029	0.0018	0.0020	0.0010	0.0012	0.0005	0.0006	0.0000	0.0000
30	0.0012	0.0015	0.0011	0.0013	0.0011	0.0011	0.0010	0.0009	0.0005	0.0005	0.0000	0.0000
35	0.0006	0.0007	0.0006	0.0007	0.0005	0.0006	0.0005	0.0005	0.0003	0.0002	0.0000	0.0000

Termination with Vested Benefits

Rates vary by entry age and service for Miscellaneous plans. Rates vary by service for Safety plans. See sample rates in tables below.

Public Agency Miscellaneous

Duration of Service	Entry Age 20		Entry Age 25		Entry Age 30		Entry Age 35		Entry Age 40	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
5	0.0381	0.0524	0.0381	0.0524	0.0358	0.0464	0.0334	0.0405	0.0301	0.0380
10	0.0265	0.0362	0.0265	0.0362	0.0254	0.0334	0.0244	0.0307	0.0197	0.0236
15	0.0180	0.0252	0.0180	0.0252	0.0166	0.0213	0.0152	0.0174	0.0119	0.0132
20	0.0141	0.0175	0.0141	0.0175	0.0110	0.0131	0.0079	0.0087	0.0000	0.0000
25	0.0084	0.0108	0.0084	0.0108	0.0064	0.0076	0.0000	0.0000	0.0000	0.0000
30	0.0047	0.0056	0.0047	0.0056	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
35	0.0038	0.0041	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000

Public Agency Safety

Duration of Service	Fire		Police		County Peace Officer	
	Male	Female	Male	Female	Male	Female
5	0.0089	0.0224	0.0156	0.0272	0.0177	0.0266
10	0.0066	0.0164	0.0113	0.0198	0.0126	0.0189
15	0.0048	0.0120	0.0083	0.0144	0.0089	0.0134
20	0.0035	0.0088	0.0060	0.0105	0.0063	0.0095
25	0.0024	0.0061	0.0042	0.0073	0.0042	0.0063
30	0.0012	0.0031	0.0021	0.0037	0.0021	0.0031
35	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000

- After termination with vested benefits, a Miscellaneous member is assumed to retire at age 59 and a Safety member at age 54.
- The Police termination with vested benefits rates are also used for Public Agency Local Prosecutors, Other Safety, Local Sheriff, and School Police.

Schools

Duration of Service	Entry Age 20		Entry Age 25		Entry Age 30		Entry Age 35		Entry Age 40	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
5	0.0359	0.0501	0.0359	0.0501	0.0332	0.0402	0.0305	0.0304	0.0266	0.0272
10	0.0311	0.0417	0.0311	0.0417	0.0269	0.0341	0.0228	0.0265	0.0193	0.0233
15	0.0193	0.0264	0.0193	0.0264	0.0172	0.0220	0.0151	0.0175	0.0123	0.0142
20	0.0145	0.0185	0.0145	0.0185	0.0113	0.0141	0.0080	0.0097	0.0000	0.0000
25	0.0089	0.0123	0.0089	0.0123	0.0074	0.0093	0.0000	0.0000	0.0000	0.0000
30	0.0057	0.0064	0.0057	0.0064	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
35	0.0040	0.0049	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000

Non-Industrial (Not Job-Related) Disability

Rates vary by age and gender for Miscellaneous plans. Rates vary by age and category for Safety plans.

	Miscellaneous		Fire	Police	County Peace Officer	Schools	
Age	Male	Female	Male and Female	Male and Female	Male and Female	Male	Female
20	0.0001	0.0000	0.0001	0.0001	0.0001	0.0000	0.0002
25	0.0001	0.0001	0.0001	0.0001	0.0001	0.0000	0.0002
30	0.0002	0.0003	0.0001	0.0001	0.0001	0.0002	0.0002
35	0.0004	0.0007	0.0001	0.0002	0.0003	0.0005	0.0004
40	0.0009	0.0012	0.0001	0.0002	0.0006	0.0010	0.0008
45	0.0015	0.0019	0.0002	0.0003	0.0011	0.0019	0.0015
50	0.0015	0.0019	0.0004	0.0005	0.0016	0.0027	0.0021
55	0.0014	0.0013	0.0006	0.0007	0.0009	0.0024	0.0017
60	0.0012	0.0009	0.0006	0.0011	0.0005	0.0020	0.0010

- The Miscellaneous non-industrial disability rates are used for Local Prosecutors.
- The police non-industrial disability rates are also used for Other Safety, Local Sheriff, and School Police.

Industrial (Job-Related) Disability

Rates vary by age and category.

Age	Fire	Police	County Peace Officer
20	0.0001	0.0000	0.0004
25	0.0002	0.0017	0.0013
30	0.0006	0.0048	0.0025
35	0.0012	0.0079	0.0037
40	0.0023	0.0110	0.0051
45	0.0040	0.0141	0.0067
50	0.0208	0.0185	0.0092
55	0.0307	0.0479	0.0151
60	0.0438	0.0602	0.0174

- The police industrial disability rates are also used for Local Sheriff and Other Safety.
- 50% of the police industrial disability rates are used for School Police.
- 1% of the police industrial disability rates are used for Local Prosecutors.
- Normally, rates are zero for Miscellaneous plans unless the agency has specifically contracted for industrial disability benefits. If so, each Miscellaneous non-industrial disability rate will be split into two components: 50% will become the non-industrial disability rate and 50% will become the industrial disability rate.

Service Retirement

Retirement rates vary by age, service, and formula, except for the Safety Half Pay at 55 and 2% at 55 formulas, where retirement rates vary by age only.

Public Agency Miscellaneous 1.5% at 65

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.008	0.011	0.013	0.015	0.017	0.019
51	0.007	0.010	0.012	0.013	0.015	0.017
52	0.010	0.014	0.017	0.019	0.021	0.024
53	0.008	0.012	0.015	0.017	0.019	0.022
54	0.012	0.016	0.019	0.022	0.025	0.028
55	0.018	0.025	0.031	0.035	0.038	0.043
56	0.015	0.021	0.025	0.029	0.032	0.036
57	0.020	0.028	0.033	0.038	0.043	0.048
58	0.024	0.033	0.040	0.046	0.052	0.058
59	0.028	0.039	0.048	0.054	0.060	0.067
60	0.049	0.069	0.083	0.094	0.105	0.118
61	0.062	0.087	0.106	0.120	0.133	0.150
62	0.104	0.146	0.177	0.200	0.223	0.251
63	0.099	0.139	0.169	0.191	0.213	0.239
64	0.097	0.136	0.165	0.186	0.209	0.233
65	0.140	0.197	0.240	0.271	0.302	0.339
66	0.092	0.130	0.157	0.177	0.198	0.222
67	0.129	0.181	0.220	0.249	0.277	0.311
68	0.092	0.129	0.156	0.177	0.197	0.221
69	0.092	0.130	0.158	0.178	0.199	0.224
70	0.103	0.144	0.175	0.198	0.221	0.248

Public Agency Miscellaneous 2% at 60

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.010	0.011	0.014	0.014	0.017	0.017
51	0.017	0.013	0.014	0.010	0.010	0.010
52	0.014	0.014	0.018	0.015	0.016	0.016
53	0.015	0.012	0.013	0.010	0.011	0.011
54	0.006	0.010	0.017	0.016	0.018	0.018
55	0.012	0.016	0.024	0.032	0.036	0.036
56	0.010	0.014	0.023	0.030	0.034	0.034
57	0.006	0.018	0.030	0.040	0.044	0.044
58	0.022	0.023	0.033	0.042	0.046	0.046
59	0.039	0.033	0.040	0.047	0.050	0.050
60	0.063	0.069	0.074	0.090	0.137	0.116
61	0.044	0.058	0.066	0.083	0.131	0.113
62	0.084	0.107	0.121	0.153	0.238	0.205
63	0.173	0.166	0.165	0.191	0.283	0.235
64	0.120	0.145	0.164	0.147	0.160	0.172
65	0.138	0.160	0.214	0.216	0.237	0.283
66	0.198	0.228	0.249	0.216	0.228	0.239
67	0.207	0.242	0.230	0.233	0.233	0.233
68	0.201	0.234	0.225	0.231	0.231	0.231
69	0.152	0.173	0.164	0.166	0.166	0.166
70	0.200	0.200	0.200	0.200	0.200	0.200

Service Retirement

Public Agency Miscellaneous 2% at 55

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.014	0.014	0.017	0.021	0.023	0.024
51	0.013	0.017	0.017	0.018	0.018	0.019
52	0.013	0.018	0.018	0.020	0.020	0.021
53	0.013	0.019	0.021	0.024	0.025	0.026
54	0.017	0.025	0.028	0.032	0.033	0.035
55	0.045	0.042	0.053	0.086	0.098	0.123
56	0.018	0.036	0.056	0.086	0.102	0.119
57	0.041	0.046	0.056	0.076	0.094	0.120
58	0.052	0.044	0.048	0.074	0.106	0.123
59	0.043	0.058	0.073	0.092	0.105	0.126
60	0.059	0.064	0.083	0.115	0.154	0.170
61	0.087	0.074	0.087	0.107	0.147	0.168
62	0.115	0.123	0.151	0.180	0.227	0.237
63	0.116	0.127	0.164	0.202	0.252	0.261
64	0.084	0.138	0.153	0.190	0.227	0.228
65	0.167	0.187	0.210	0.262	0.288	0.291
66	0.187	0.258	0.280	0.308	0.318	0.319
67	0.195	0.235	0.244	0.277	0.269	0.280
68	0.228	0.248	0.250	0.241	0.245	0.245
69	0.188	0.201	0.209	0.219	0.231	0.231
70	0.229	0.229	0.229	0.229	0.229	0.229

Public Agency Miscellaneous 2.5% at 55

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.014	0.017	0.027	0.035	0.046	0.050
51	0.019	0.021	0.025	0.030	0.038	0.040
52	0.018	0.020	0.026	0.034	0.038	0.037
53	0.013	0.021	0.031	0.045	0.052	0.053
54	0.025	0.025	0.030	0.046	0.057	0.068
55	0.029	0.042	0.064	0.109	0.150	0.225
56	0.036	0.047	0.068	0.106	0.134	0.194
57	0.051	0.047	0.060	0.092	0.116	0.166
58	0.035	0.046	0.062	0.093	0.119	0.170
59	0.029	0.053	0.072	0.112	0.139	0.165
60	0.039	0.069	0.094	0.157	0.177	0.221
61	0.080	0.077	0.086	0.140	0.167	0.205
62	0.086	0.131	0.149	0.220	0.244	0.284
63	0.135	0.135	0.147	0.214	0.222	0.262
64	0.114	0.128	0.158	0.177	0.233	0.229
65	0.112	0.174	0.222	0.209	0.268	0.273
66	0.235	0.254	0.297	0.289	0.321	0.337
67	0.237	0.240	0.267	0.249	0.267	0.277
68	0.258	0.271	0.275	0.207	0.210	0.212
69	0.117	0.208	0.266	0.219	0.250	0.270
70	0.229	0.229	0.229	0.229	0.229	0.229

Service Retirement

Public Agency Miscellaneous 2.7% at 55

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.011	0.016	0.022	0.033	0.034	0.038
51	0.018	0.019	0.023	0.032	0.031	0.031
52	0.019	0.020	0.026	0.035	0.034	0.037
53	0.020	0.020	0.025	0.043	0.048	0.053
54	0.018	0.030	0.040	0.052	0.053	0.070
55	0.045	0.058	0.082	0.138	0.208	0.278
56	0.057	0.062	0.080	0.121	0.178	0.222
57	0.045	0.052	0.071	0.106	0.147	0.182
58	0.074	0.060	0.074	0.118	0.163	0.182
59	0.058	0.067	0.086	0.123	0.158	0.187
60	0.087	0.084	0.096	0.142	0.165	0.198
61	0.073	0.084	0.101	0.138	0.173	0.218
62	0.130	0.133	0.146	0.187	0.214	0.249
63	0.122	0.140	0.160	0.204	0.209	0.243
64	0.104	0.124	0.154	0.202	0.214	0.230
65	0.182	0.201	0.242	0.264	0.293	0.293
66	0.272	0.249	0.273	0.285	0.312	0.312
67	0.182	0.217	0.254	0.249	0.264	0.264
68	0.223	0.197	0.218	0.242	0.273	0.273
69	0.217	0.217	0.217	0.217	0.217	0.217
70	0.227	0.227	0.227	0.227	0.227	0.227

Public Agency Miscellaneous 3% at 60

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.015	0.020	0.025	0.039	0.040	0.044
51	0.041	0.034	0.032	0.041	0.036	0.037
52	0.024	0.020	0.022	0.039	0.040	0.041
53	0.018	0.024	0.032	0.047	0.048	0.057
54	0.033	0.033	0.035	0.051	0.049	0.052
55	0.137	0.043	0.051	0.065	0.076	0.108
56	0.173	0.038	0.054	0.075	0.085	0.117
57	0.019	0.035	0.059	0.088	0.111	0.134
58	0.011	0.040	0.070	0.105	0.133	0.162
59	0.194	0.056	0.064	0.081	0.113	0.163
60	0.081	0.085	0.133	0.215	0.280	0.333
61	0.080	0.090	0.134	0.170	0.223	0.292
62	0.137	0.153	0.201	0.250	0.278	0.288
63	0.128	0.140	0.183	0.227	0.251	0.260
64	0.174	0.147	0.173	0.224	0.239	0.264
65	0.152	0.201	0.262	0.299	0.323	0.323
66	0.272	0.273	0.317	0.355	0.380	0.380
67	0.218	0.237	0.268	0.274	0.284	0.284
68	0.200	0.228	0.269	0.285	0.299	0.299
69	0.250	0.250	0.250	0.250	0.250	0.250
70	0.245	0.245	0.245	0.245	0.245	0.245

Service Retirement

Public Agency Miscellaneous 2% at 62

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.000	0.000	0.000	0.000	0.000	0.000
51	0.000	0.000	0.000	0.000	0.000	0.000
52	0.005	0.008	0.012	0.015	0.019	0.031
53	0.007	0.011	0.014	0.018	0.021	0.032
54	0.007	0.011	0.015	0.019	0.023	0.034
55	0.010	0.019	0.028	0.036	0.061	0.096
56	0.014	0.026	0.038	0.050	0.075	0.108
57	0.018	0.029	0.039	0.050	0.074	0.107
58	0.023	0.035	0.048	0.060	0.073	0.099
59	0.025	0.038	0.051	0.065	0.092	0.128
60	0.031	0.051	0.071	0.091	0.111	0.138
61	0.038	0.058	0.079	0.100	0.121	0.167
62	0.044	0.074	0.104	0.134	0.164	0.214
63	0.077	0.105	0.134	0.163	0.192	0.237
64	0.072	0.101	0.129	0.158	0.187	0.242
65	0.108	0.141	0.173	0.206	0.239	0.300
66	0.132	0.172	0.212	0.252	0.292	0.366
67	0.132	0.172	0.212	0.252	0.292	0.366
68	0.120	0.156	0.193	0.229	0.265	0.333
69	0.120	0.156	0.193	0.229	0.265	0.333
70	0.120	0.156	0.193	0.229	0.265	0.333

Service Retirement

Public Agency Fire Half Pay at 55 and 2% at 55

Age	Rate	Age	Rate
50	0.016	56	0.111
51	0.000	57	0.000
52	0.034	58	0.095
53	0.020	59	0.044
54	0.041	60	1.000
55	0.075		

Public Agency Police Half Pay at 55 and 2% at 55

Age	Rate	Age	Rate
50	0.026	56	0.069
51	0.000	57	0.051
52	0.016	58	0.072
53	0.027	59	0.070
54	0.010	60	0.300
55	0.167		

Service Retirement

Public Agency Police 2% at 50

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.018	0.077	0.056	0.046	0.043	0.046
51	0.022	0.087	0.060	0.048	0.044	0.047
52	0.020	0.102	0.081	0.071	0.069	0.075
53	0.016	0.072	0.053	0.045	0.042	0.046
54	0.006	0.071	0.071	0.069	0.072	0.080
55	0.009	0.040	0.099	0.157	0.186	0.186
56	0.020	0.051	0.108	0.165	0.194	0.194
57	0.036	0.072	0.106	0.139	0.156	0.156
58	0.001	0.046	0.089	0.130	0.152	0.152
59	0.066	0.094	0.119	0.143	0.155	0.155
60	0.177	0.177	0.177	0.177	0.177	0.177
61	0.134	0.134	0.134	0.134	0.134	0.134
62	0.184	0.184	0.184	0.184	0.184	0.184
63	0.250	0.250	0.250	0.250	0.250	0.250
64	0.177	0.177	0.177	0.177	0.177	0.177
65	1.000	1.000	1.000	1.000	1.000	1.000

- These rates also apply to County Peace officers, Local Prosecutors, Local Sheriff, School Police, and Other Safety.

Service Retirement

Public Agency Fire 2% at 50

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.054	0.054	0.056	0.080	0.064	0.066
51	0.020	0.020	0.021	0.030	0.024	0.024
52	0.037	0.037	0.038	0.054	0.043	0.045
53	0.051	0.051	0.053	0.076	0.061	0.063
54	0.082	0.082	0.085	0.121	0.097	0.100
55	0.139	0.139	0.139	0.139	0.139	0.139
56	0.129	0.129	0.129	0.129	0.129	0.129
57	0.085	0.085	0.085	0.085	0.085	0.085
58	0.119	0.119	0.119	0.119	0.119	0.119
59	0.167	0.167	0.167	0.167	0.167	0.167
60	0.152	0.152	0.152	0.152	0.152	0.152
61	0.179	0.179	0.179	0.179	0.179	0.179
62	0.179	0.179	0.179	0.179	0.179	0.179
63	0.179	0.179	0.179	0.179	0.179	0.179
64	0.179	0.179	0.179	0.179	0.179	0.179
65	1.000	1.000	1.000	1.000	1.000	1.000

Service Retirement

Public Agency Police 3% at 55

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.019	0.053	0.045	0.054	0.057	0.061
51	0.002	0.017	0.028	0.044	0.053	0.060
52	0.002	0.031	0.037	0.051	0.059	0.066
53	0.026	0.049	0.049	0.080	0.099	0.114
54	0.019	0.034	0.047	0.091	0.121	0.142
55	0.006	0.115	0.141	0.199	0.231	0.259
56	0.017	0.188	0.121	0.173	0.199	0.199
57	0.008	0.137	0.093	0.136	0.157	0.157
58	0.017	0.126	0.105	0.164	0.194	0.194
59	0.026	0.146	0.110	0.167	0.195	0.195
60	0.155	0.155	0.155	0.155	0.155	0.155
61	0.210	0.210	0.210	0.210	0.210	0.210
62	0.262	0.262	0.262	0.262	0.262	0.262
63	0.172	0.172	0.172	0.172	0.172	0.172
64	0.227	0.227	0.227	0.227	0.227	0.227
65	1.000	1.000	1.000	1.000	1.000	1.000

- These rates also apply to County Peace officers, Local Prosecutors, Local Sheriff, School Police, and Other Safety.

Service Retirement

Public Agency Fire 3% at 55

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.003	0.006	0.013	0.019	0.025	0.028
51	0.004	0.008	0.017	0.026	0.034	0.038
52	0.005	0.011	0.022	0.033	0.044	0.049
53	0.005	0.034	0.024	0.038	0.069	0.138
54	0.007	0.047	0.032	0.051	0.094	0.187
55	0.010	0.067	0.046	0.073	0.134	0.266
56	0.010	0.063	0.044	0.069	0.127	0.253
57	0.135	0.100	0.148	0.196	0.220	0.220
58	0.083	0.062	0.091	0.120	0.135	0.135
59	0.137	0.053	0.084	0.146	0.177	0.177
60	0.162	0.063	0.099	0.172	0.208	0.208
61	0.598	0.231	0.231	0.231	0.231	0.231
62	0.621	0.240	0.240	0.240	0.240	0.240
63	0.236	0.236	0.236	0.236	0.236	0.236
64	0.236	0.236	0.236	0.236	0.236	0.236
65	1.000	1.000	1.000	1.000	1.000	1.000

Service Retirement

Public Agency Police 3% at 50

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.124	0.103	0.113	0.143	0.244	0.376
51	0.060	0.081	0.087	0.125	0.207	0.294
52	0.016	0.055	0.111	0.148	0.192	0.235
53	0.072	0.074	0.098	0.142	0.189	0.237
54	0.018	0.049	0.105	0.123	0.187	0.271
55	0.069	0.074	0.081	0.113	0.209	0.305
56	0.064	0.108	0.113	0.125	0.190	0.288
57	0.056	0.109	0.160	0.182	0.210	0.210
58	0.108	0.129	0.173	0.189	0.214	0.214
59	0.093	0.144	0.204	0.229	0.262	0.262
60	0.343	0.180	0.159	0.188	0.247	0.247
61	0.221	0.221	0.221	0.221	0.221	0.221
62	0.213	0.213	0.213	0.213	0.213	0.213
63	0.233	0.233	0.233	0.233	0.233	0.233
64	0.234	0.234	0.234	0.234	0.234	0.234
65	1.000	1.000	1.000	1.000	1.000	1.000

- These rates also apply to County Peace officers, Local Prosecutors, Local Sheriff, School Police, and Other Safety.

Service Retirement

Public Agency Fire 3% at 50

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.095	0.048	0.053	0.093	0.134	0.175
51	0.016	0.032	0.053	0.085	0.117	0.149
52	0.013	0.032	0.054	0.087	0.120	0.154
53	0.085	0.044	0.049	0.089	0.129	0.170
54	0.038	0.065	0.074	0.105	0.136	0.167
55	0.042	0.043	0.049	0.085	0.132	0.215
56	0.133	0.103	0.075	0.113	0.151	0.209
57	0.062	0.048	0.060	0.124	0.172	0.213
58	0.124	0.097	0.092	0.153	0.194	0.227
59	0.092	0.071	0.078	0.144	0.192	0.233
60	0.056	0.044	0.061	0.131	0.186	0.233
61	0.282	0.219	0.158	0.198	0.233	0.260
62	0.292	0.227	0.164	0.205	0.241	0.269
63	0.196	0.196	0.196	0.196	0.196	0.196
64	0.197	0.197	0.197	0.197	0.197	0.197
65	1.000	1.000	1.000	1.000	1.000	1.000

Back to Agenda Back to Item

Service Retirement

Public Agency Police 2% at 57

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.040	0.040	0.040	0.040	0.040	0.080
51	0.028	0.028	0.028	0.028	0.040	0.066
52	0.028	0.028	0.028	0.028	0.043	0.061
53	0.028	0.028	0.028	0.028	0.057	0.086
54	0.028	0.028	0.028	0.032	0.069	0.110
55	0.050	0.050	0.050	0.067	0.099	0.179
56	0.046	0.046	0.046	0.062	0.090	0.160
57	0.054	0.054	0.054	0.072	0.106	0.191
58	0.060	0.060	0.060	0.066	0.103	0.171
59	0.060	0.060	0.060	0.069	0.105	0.171
60	0.113	0.113	0.113	0.113	0.113	0.171
61	0.108	0.108	0.108	0.108	0.108	0.128
62	0.113	0.113	0.113	0.113	0.113	0.159
63	0.113	0.113	0.113	0.113	0.113	0.159
64	0.113	0.113	0.113	0.113	0.113	0.239
65	1.000	1.000	1.000	1.000	1.000	1.000

- These rates also apply to County Peace officers, Local Prosecutors, Local Sheriff, School Police, and Other Safety.

Service Retirement

Public Agency Fire 2% at 57

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.005	0.005	0.005	0.005	0.008	0.012
51	0.006	0.006	0.006	0.006	0.009	0.013
52	0.012	0.012	0.012	0.012	0.019	0.028
53	0.033	0.033	0.033	0.033	0.050	0.075
54	0.045	0.045	0.045	0.045	0.069	0.103
55	0.061	0.061	0.061	0.061	0.094	0.140
56	0.055	0.055	0.055	0.055	0.084	0.126
57	0.081	0.081	0.081	0.081	0.125	0.187
58	0.059	0.059	0.059	0.059	0.091	0.137
59	0.055	0.055	0.055	0.055	0.084	0.126
60	0.085	0.085	0.085	0.085	0.131	0.196
61	0.085	0.085	0.085	0.085	0.131	0.196
62	0.085	0.085	0.085	0.085	0.131	0.196
63	0.085	0.085	0.085	0.085	0.131	0.196
64	0.085	0.085	0.085	0.085	0.131	0.196
65	1.000	1.000	1.000	1.000	1.000	1.000

Service Retirement

Public Agency Police 2.5% at 57

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.050	0.050	0.050	0.050	0.050	0.100
51	0.038	0.038	0.038	0.038	0.055	0.089
52	0.038	0.038	0.038	0.038	0.058	0.082
53	0.036	0.036	0.036	0.036	0.073	0.111
54	0.036	0.036	0.036	0.041	0.088	0.142
55	0.061	0.061	0.061	0.082	0.120	0.217
56	0.056	0.056	0.056	0.075	0.110	0.194
57	0.060	0.060	0.060	0.080	0.118	0.213
58	0.072	0.072	0.072	0.079	0.124	0.205
59	0.072	0.072	0.072	0.083	0.126	0.205
60	0.135	0.135	0.135	0.135	0.135	0.205
61	0.130	0.130	0.130	0.130	0.130	0.153
62	0.135	0.135	0.135	0.135	0.135	0.191
63	0.135	0.135	0.135	0.135	0.135	0.191
64	0.135	0.135	0.135	0.135	0.135	0.287
65	1.000	1.000	1.000	1.000	1.000	1.000

- These rates also apply to County Peace officers, Local Prosecutors, Local Sheriff, School Police, and Other Safety.

Service Retirement

Public Agency Fire 2.5% at 57

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.007	0.007	0.007	0.007	0.010	0.015
51	0.008	0.008	0.008	0.008	0.012	0.018
52	0.016	0.016	0.016	0.016	0.025	0.038
53	0.042	0.042	0.042	0.042	0.064	0.096
54	0.057	0.057	0.057	0.057	0.088	0.132
55	0.074	0.074	0.074	0.074	0.114	0.170
56	0.066	0.066	0.066	0.066	0.102	0.153
57	0.090	0.090	0.090	0.090	0.139	0.208
58	0.071	0.071	0.071	0.071	0.110	0.164
59	0.066	0.066	0.066	0.066	0.101	0.151
60	0.102	0.102	0.102	0.102	0.157	0.235
61	0.102	0.102	0.102	0.102	0.157	0.236
62	0.102	0.102	0.102	0.102	0.157	0.236
63	0.102	0.102	0.102	0.102	0.157	0.236
64	0.102	0.102	0.102	0.102	0.157	0.236
65	1.000	1.000	1.000	1.000	1.000	1.000

Service Retirement

Public Agency Police 2.7% at 57

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.050	0.050	0.050	0.050	0.050	0.100
51	0.040	0.040	0.040	0.040	0.058	0.094
52	0.038	0.038	0.038	0.038	0.058	0.083
53	0.038	0.038	0.038	0.038	0.077	0.117
54	0.038	0.038	0.038	0.044	0.093	0.150
55	0.068	0.068	0.068	0.091	0.134	0.242
56	0.063	0.063	0.063	0.084	0.123	0.217
57	0.060	0.060	0.060	0.080	0.118	0.213
58	0.080	0.080	0.080	0.088	0.138	0.228
59	0.080	0.080	0.080	0.092	0.140	0.228
60	0.150	0.150	0.150	0.150	0.150	0.228
61	0.144	0.144	0.144	0.144	0.144	0.170
62	0.150	0.150	0.150	0.150	0.150	0.213
63	0.150	0.150	0.150	0.150	0.150	0.213
64	0.150	0.150	0.150	0.150	0.150	0.319
65	1.000	1.000	1.000	1.000	1.000	1.000

- These rates also apply to County Peace officers, Local Prosecutors, Local Sheriff, School Police, and Other Safety.

Service Retirement

Public Agency Fire 2.7% at 57

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.007	0.007	0.007	0.007	0.010	0.015
51	0.008	0.008	0.008	0.008	0.013	0.019
52	0.016	0.016	0.016	0.016	0.025	0.038
53	0.044	0.044	0.044	0.044	0.068	0.102
54	0.061	0.061	0.061	0.061	0.093	0.140
55	0.083	0.083	0.083	0.083	0.127	0.190
56	0.074	0.074	0.074	0.074	0.114	0.171
57	0.090	0.090	0.090	0.090	0.139	0.208
58	0.079	0.079	0.079	0.079	0.122	0.182
59	0.073	0.073	0.073	0.073	0.112	0.168
60	0.114	0.114	0.114	0.114	0.175	0.262
61	0.114	0.114	0.114	0.114	0.175	0.262
62	0.114	0.114	0.114	0.114	0.175	0.262
63	0.114	0.114	0.114	0.114	0.175	0.262
64	0.114	0.114	0.114	0.114	0.175	0.262
65	1.000	1.000	1.000	1.000	1.000	1.000

Service Retirement

Schools 2% at 55

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.003	0.004	0.006	0.007	0.010	0.010
51	0.004	0.005	0.007	0.008	0.011	0.011
52	0.005	0.007	0.008	0.009	0.012	0.012
53	0.007	0.008	0.010	0.012	0.015	0.015
54	0.006	0.009	0.012	0.015	0.020	0.021
55	0.011	0.023	0.034	0.057	0.070	0.090
56	0.012	0.027	0.036	0.056	0.073	0.095
57	0.016	0.027	0.036	0.055	0.068	0.087
58	0.019	0.030	0.040	0.062	0.078	0.103
59	0.023	0.034	0.046	0.070	0.085	0.109
60	0.022	0.043	0.062	0.095	0.113	0.141
61	0.030	0.051	0.071	0.103	0.124	0.154
62	0.065	0.098	0.128	0.188	0.216	0.248
63	0.075	0.112	0.144	0.197	0.222	0.268
64	0.091	0.116	0.138	0.180	0.196	0.231
65	0.163	0.164	0.197	0.232	0.250	0.271
66	0.208	0.204	0.243	0.282	0.301	0.315
67	0.189	0.185	0.221	0.257	0.274	0.287
68	0.127	0.158	0.200	0.227	0.241	0.244
69	0.168	0.162	0.189	0.217	0.229	0.238
70	0.191	0.190	0.237	0.250	0.246	0.254

Schools 2% at 62

	Duration of Service					
Age	5 Years	10 Years	15 Years	20 Years	25 Years	30 Years
50	0.000	0.000	0.000	0.000	0.000	0.000
51	0.000	0.000	0.000	0.000	0.000	0.000
52	0.004	0.007	0.010	0.011	0.013	0.015
53	0.004	0.008	0.010	0.013	0.014	0.016
54	0.005	0.011	0.015	0.018	0.020	0.022
55	0.014	0.027	0.038	0.045	0.050	0.056
56	0.013	0.026	0.037	0.043	0.048	0.055
57	0.013	0.027	0.038	0.045	0.050	0.055
58	0.017	0.034	0.047	0.056	0.062	0.069
59	0.019	0.037	0.052	0.062	0.068	0.076
60	0.026	0.053	0.074	0.087	0.097	0.108
61	0.030	0.058	0.081	0.095	0.106	0.119
62	0.053	0.105	0.147	0.174	0.194	0.217
63	0.054	0.107	0.151	0.178	0.198	0.222
64	0.053	0.105	0.147	0.174	0.194	0.216
65	0.072	0.142	0.199	0.235	0.262	0.293
66	0.077	0.152	0.213	0.252	0.281	0.314
67	0.070	0.139	0.194	0.229	0.255	0.286
68	0.063	0.124	0.173	0.205	0.228	0.255
69	0.066	0.130	0.183	0.216	0.241	0.270
70	0.071	0.140	0.196	0.231	0.258	0.289

Miscellaneous

Internal Revenue Code Section 415

The limitations on benefits imposed by Internal Revenue Code Section 415 are taken into account in this valuation. Each year the impact of any changes in this limitation since the prior valuation is included and amortized as part of the actuarial gain or loss base. This results in lower contributions for those employers contributing to the Replacement Benefit Fund and protects CalPERS from prefunding expected benefits in excess of limits imposed by federal tax law. The Section 415(b) dollar limit for the 2022 calendar year is $245,000.

Internal Revenue Code Section 401(a)(17)

The limitations on compensation imposed by Internal Revenue Code Section 401(a)(17) are taken into account in this valuation. Each year, the impact of any changes in the compensation limitation since the prior valuation is included and amortized as part of the actuarial gain or loss base. The compensation limit for classic members for the 2022 calendar year is $305,000.

Appendix B

Principal Plan Provisions

The following is a description of the principal plan provisions used in calculating costs and liabilities. We have indicated whether a plan provision is standard or optional. Standard benefits are applicable to all members while optional benefits vary among employers. Optional benefits that apply to a single period of time, such as Golden Handshakes, have not been included. Many of the statements in this summary are general in nature, and are intended to provide an easily understood summary of the Public Employees' Retirement Law and the California Public Employees' Pension Reform Act of 2013. The law itself governs in all situations.

Service Retirement

Eligibility

A classic CalPERS member or PEPRA Safety member becomes eligible for Service Retirement upon attainment of age 50 with at least 5 years of credited service (total service across all CalPERS employers, and with certain other retirement systems with which CalPERS has reciprocity agreements). For employees hired into a plan with the 1.5% at age 65 formula, eligibility for service retirement is age 55 with at least 5 years of service. PEPRA Miscellaneous members become eligible for service retirement upon attainment of age 52 with at least 5 years of service.

Benefit

The service retirement benefit is a monthly allowance equal to the product of the *benefit factor*, *years of service*, and *final compensation.*

- The *benefit factor* depends on the benefit formula specified in the agency's contract. The table below shows the factors for each of the available formulas. Factors vary by the member's age at retirement. Listed are the factors for retirement at whole year ages:

Miscellaneous Plan Formulas

Retirement Age	1.5% at 65	2% at 60	2% at 55	2.5% at 55	2.7% at 55	3% at 60	PEPRA 2% at 62
50	0.5000%	1.092%	1.426%	2.000%	2.000%	2.000%	N/A
51	0.5667%	1.156%	1.522%	2.100%	2.140%	2.100%	N/A
52	0.6334%	1.224%	1.628%	2.200%	2.280%	2.200%	1.000%
53	0.7000%	1.296%	1.742%	2.300%	2.420%	2.300%	1.100%
54	0.7667%	1.376%	1.866%	2.400%	2.560%	2.400%	1.200%
55	0.8334%	1.460%	2.000%	2.500%	2.700%	2.500%	1.300%
56	0.9000%	1.552%	2.052%	2.500%	2.700%	2.600%	1.400%
57	0.9667%	1.650%	2.104%	2.500%	2.700%	2.700%	1.500%
58	1.0334%	1.758%	2.156%	2.500%	2.700%	2.800%	1.600%
59	1.1000%	1.874%	2.210%	2.500%	2.700%	2.900%	1.700%
60	1.1667%	2.000%	2.262%	2.500%	2.700%	3.000%	1.800%
61	1.2334%	2.134%	2.314%	2.500%	2.700%	3.000%	1.900%
62	1.3000%	2.272%	2.366%	2.500%	2.700%	3.000%	2.000%
63	1.3667%	2.418%	2.418%	2.500%	2.700%	3.000%	2.100%
64	1.4334%	2.418%	2.418%	2.500%	2.700%	3.000%	2.200%
65	1.5000%	2.418%	2.418%	2.500%	2.700%	3.000%	2.300%
66	1.5000%	2.418%	2.418%	2.500%	2.700%	3.000%	2.400%
67 & up	1.5000%	2.418%	2.418%	2.500%	2.700%	3.000%	2.500%

Safety Plan Formulas

Retirement Age	Half Pay at 55*	2% at 55	2% at 50	3% at 55	3% at 50
50	1.783%	1.426%	2.000%	2.400%	3.000%
51	1.903%	1.522%	2.140%	2.520%	3.000%
52	2.035%	1.628%	2.280%	2.640%	3.000%
53	2.178%	1.742%	2.420%	2.760%	3.000%
54	2.333%	1.866%	2.560%	2.880%	3.000%
55 & Up	2.500%	2.000%	2.700%	3.000%	3.000%

* For this formula, the benefit factor also varies by entry age. The factors shown are for members with an entry age of 35 or greater. If entry age is less than 35, then the age 55 benefit factor is 50% divided by the difference between age 55 and entry age. The benefit factor for ages prior to age 55 is the same proportion of the age 55 benefit factor as in the above table.

PEPRA Safety Plan Formulas

Retirement Age	2% at 57	2.5% at 57	2.7% at 57
50	1.426%	2.000%	2.000%
51	1.508%	2.071%	2.100%
52	1.590%	2.143%	2.200%
53	1.672%	2.214%	2.300%
54	1.754%	2.286%	2.400%
55	1.836%	2.357%	2.500%
56	1.918%	2.429%	2.600%
57 & Up	2.000%	2.500%	2.700%

- The *years of service* is the amount credited by CalPERS to a member while he or she is employed in this group (or for other periods that are recognized under the employer's contract with CalPERS). For a member who has earned service with multiple CalPERS employers, the benefit from each employer is calculated separately according to each employer's contract, and then added together for the total allowance. An agency may contract for an optional benefit where any unused sick leave accumulated at the time of retirement will be converted to credited service at a rate of 0.004 years of service for each day of sick leave.

- The *final compensation* is the monthly average of the member's highest 36 or 12 consecutive months' full-time equivalent monthly pay (no matter which CalPERS employer paid this compensation). The standard benefit is 36 months. Employers had the option of providing a final compensation equal to the highest 12 consecutive months for classic plans only. Final compensation must be defined by the highest 36 consecutive months' pay under the 1.5% at 65 formula. PEPRA members have a cap on the annual salary that can be used to calculate final compensation for all new members based on the Social Security contribution and benefit base. For employees that participate in Social Security this cap is $134,974 for 2022 and for those employees that do not participate in Social Security the cap for 2022 is $161,969. Adjustments to the caps are permitted annually based on changes to the CPI for all urban consumers.

- PEPRA benefit formulas have no Social Security offsets and Social Security coverage is optional. For Classic benefit formulas, employees must be covered by Social Security with the 1.5% at 65 formula. Social Security is optional for all other Classic benefit formulas. For employees covered by Social Security, the modified formula is the standard benefit. Under this type of formula, the final compensation is offset by $133.33 (or by one third if the final compensation is less than $400). Employers may contract for the full benefit with Social Security that will eliminate the offset applicable to the final compensation. For employees not covered by Social Security, the full

benefit is paid with no offsets. Auxiliary organizations of the CSUC system may elect reduced contribution rates, in which case the offset is $317 if members are not covered by Social Security or $513 if members are covered by Social Security.

- The Miscellaneous and PEPRA Safety service retirement benefit is not capped. The Classic Safety service retirement benefit is capped at 90% of final compensation.

Vested Deferred Retirement

Eligibility for Deferred Status

A CalPERS member becomes eligible for a deferred vested retirement benefit when he or she leaves employment, keeps his or her contribution account balance on deposit with CalPERS, **and** has earned at least 5 years of credited service (total service across all CalPERS employers, and with certain other retirement systems with which CalPERS has reciprocity agreements).

Eligibility to Start Receiving Benefits

The CalPERS classic members and PEPRA Safety members become eligible to receive the deferred retirement benefit upon satisfying the eligibility requirements for deferred status and upon attainment of age 50 (55 for employees hired into a 1.5% at 65 plan). PEPRA Miscellaneous members become eligible to receive the deferred retirement benefit upon satisfying the eligibility requirements for deferred status and upon attainment of age 52.

Benefit

The vested deferred retirement benefit is the same as the service retirement benefit, where the benefit factor is based on the member's age at allowance commencement. For members who have earned service with multiple CalPERS employers, the benefit from each employer is calculated separately according to each employer's contract, and then added together for the total allowance.

Non-Industrial (Non-Job Related) Disability Retirement

Eligibility

A CalPERS member is eligible for Non-Industrial Disability Retirement if he or she becomes *disabled* and has at least 5 years of credited service (total service across all CalPERS employers, and with certain other retirement systems with which CalPERS has reciprocity agreements). There is no special age requirement. *Disabled* means the member is unable to perform his or her job because of an illness or injury, which is expected to be permanent or to last indefinitely. The illness or injury does not have to be job related. A CalPERS member must be actively employed by any CalPERS employer at the time of disability in order to be eligible for this benefit.

Standard Benefit

The standard Non-Industrial Disability Retirement benefit is a monthly allowance equal to 1.8% of final compensation, multiplied by *service*, which is determined as follows:

- *Service* is CalPERS credited service, for members with less than 10 years of service or greater than 18.518 years of service; or

- *Service* is CalPERS credited service plus the additional number of years that the member would have worked until age 60, for members with at least 10 years but not more than 18.518 years of service. The maximum benefit in this case is 33⅓% of final compensation.

Back to Agenda Back to Item

Improved Benefit

Employers have the option of providing the improved Non-Industrial Disability Retirement benefit. This benefit provides a monthly allowance equal to 30% of final compensation for the first 5 years of service, plus 1% for each additional year of service to a maximum of 50% of final compensation.

Members who are eligible for a larger service retirement benefit may choose to receive that benefit in lieu of a disability benefit. Members eligible to retire, and who have attained the normal retirement age determined by their service retirement benefit formula, will receive the same dollar amount for disability retirement as that payable for service retirement. For members who have earned service with multiple CalPERS employers, the benefit attributed to each employer is the total disability allowance multiplied by the ratio of service with a particular employer to the total CalPERS service.

Industrial (Job Related) Disability Retirement

This is a standard benefit for Safety members except those described in Section 20423.6. For excluded Safety members and all Miscellaneous members, employers have the option of providing this benefit. An employer may choose to provide the increased benefit option or the improved benefit option.

Eligibility

An employee is eligible for Industrial Disability Retirement if he or she becomes disabled while working, where disabled means the member is unable to perform the duties of the job because of a work-related illness or injury, which is expected to be permanent or to last indefinitely. A CalPERS member who has left active employment within this group is not eligible for this benefit, except to the extent described below.

Standard Benefit

The standard Industrial Disability Retirement benefit is a monthly allowance equal to 50% of final compensation.

Increased Benefit (75% of Final Compensation)

The increased Industrial Disability Retirement benefit is a monthly allowance equal to 75% of final compensation for total disability.

Improved Benefit (50% to 90% of Final Compensation)

The improved Industrial Disability Retirement benefit is a monthly allowance equal to the Workman's Compensation Appeals Board permanent disability rate percentage (if 50% or greater, with a maximum of 90%) times the final compensation.

For a CalPERS member not actively employed in this group who became disabled while employed by some other CalPERS employer, the benefit is a return of accumulated member contributions with respect to employment in this group. With the standard or increased benefit, a member may also choose to receive the annuitization of the accumulated member contributions.

If a member is eligible for service retirement and if the service retirement benefit is more than the industrial disability retirement benefit, the member may choose to receive the larger benefit.

Post-Retirement Death Benefit

Standard Lump Sum Payment

Upon the death of a retiree, a one-time lump sum payment of $500 will be made to the retiree's designated survivor(s), or to the retiree's estate. The lump sum payment amount increases to $2,000 for any death occurring on or after July 1, 2023 due to SB 1168.

Optional Lump Sum Payment

In lieu of the standard lump sum death benefit, employers have the option of providing a lump sum death benefit of $600, $3,000, $4,000 or $5,000.

Form of Payment for Retirement Allowance

Standard Form of Payment

Generally, the retirement allowance is paid to the retiree in the form of an annuity for as long as he or she is alive. The retiree may choose to provide for a portion of his or her allowance to be paid to any designated beneficiary after the retiree's death. CalPERS provides for a variety of such benefit options, which the retiree pays for by taking a reduction in his or her retirement allowance. Such reduction takes into account the amount to be provided to the beneficiary and the probable duration of payments (based on the ages of the member and beneficiary) made subsequent to the member's death.

Improved Form of Payment (Post-Retirement Survivor Allowance)

Employers have the option to contract for the post-retirement survivor allowance.

For retirement allowances with respect to service subject to a modified Classic formula, 25% of the retirement allowance will automatically be continued to certain statutory beneficiaries upon the death of the retiree, without a reduction in the retiree's allowance. For retirement allowances with respect to service subject to a PEPRA formula or a full or supplemental Classic formula, 50% of the retirement allowance will automatically be continued to certain statutory beneficiaries upon the death of the retiree, without a reduction in the retiree's allowance. This additional benefit is referred to as post-retirement survivor allowance (PRSA) or simply as survivor continuance.

In other words, 25% or 50% of the allowance, the continuance portion, is paid to the retiree for as long as he or she is alive, and that same amount is continued to the retiree's spouse (or if no eligible spouse, to unmarried child(ren) until they attain age 18; or, if no eligible child(ren), to a qualifying dependent parent) for the rest of his or her lifetime. This benefit will not be discontinued in the event the spouse remarries.

The remaining 75% or 50% of the retirement allowance, which may be referred to as the option portion of the benefit, is paid to the retiree as an annuity for as long as he or she is alive. Or, the retiree may choose to provide for some of this option portion to be paid to any designated beneficiary after the retiree's death. Benefit options applicable to the option portion are the same as those offered with the standard form. The reduction is calculated in the same manner but is applied only to the option portion.

Back to Agenda Back to Item

Pre-Retirement Death Benefits

Basic Death Benefit

This is a standard benefit.

Eligibility

An employee's beneficiary (or estate) may receive the basic death benefit if the member dies while actively employed. A CalPERS member must be actively employed with the CalPERS employer providing this benefit to be eligible for this benefit. A member's survivor who is eligible for any other pre-retirement death benefit may choose to receive that death benefit instead of this basic death benefit.

Benefit

The basic death benefit is a lump sum in the amount of the member's accumulated contributions, where interest is credited annually at the greater of 6% or the prevailing discount rate through the date of death, plus a lump sum in the amount of one month's salary for each completed year of current service, up to a maximum of six months' salary. For purposes of this benefit, one month's salary is defined as the member's average monthly full-time rate of compensation during the 12 months preceding death.

1957 Survivor Benefit

This is a standard benefit.

Eligibility

An employee's *eligible survivor(s)* may receive the 1957 Survivor benefit if the member dies while actively employed, has attained at least age 50 for classic and PEPRA Safety members and age 52 for PEPRA Miscellaneous members, and has at least 5 years of credited service (total service across all CalPERS employers and with certain other retirement systems with which CalPERS has reciprocity agreements). A CalPERS member must be actively employed with the CalPERS employer providing this benefit to be eligible for this benefit. An eligible survivor means the surviving spouse to whom the member was married at least one year before death or, if there is no eligible spouse, to the member's unmarried child(ren) under age 18. A member's survivor who is eligible for any other pre-retirement death benefit may choose to receive that death benefit instead of this 1957 Survivor benefit.

Benefit

The 1957 Survivor benefit is a monthly allowance equal to one-half of the unmodified service retirement benefit that the member would have been entitled to receive if the member had retired on the date of his or her death. If the benefit is payable to the spouse, the benefit is discontinued upon the death of the spouse. If the benefit is payable to dependent child(ren), the benefit will be discontinued upon death or attainment of age 18, unless the child(ren) is disabled. The total amount paid will be at least equal to the basic death benefit.

Optional Settlement 2 Death Benefit

This is an optional benefit.

Eligibility

An employee's *eligible survivor* may receive the Optional Settlement 2 Death benefit if the member dies while actively employed, has attained at least age 50 for classic and PEPRA Safety members and age 52 for PEPRA Miscellaneous members, and has at least 5 years of credited service (total service across all CalPERS employers and with certain other retirement systems with which CalPERS has reciprocity agreements). A CalPERS member who is no longer actively employed with **any** CalPERS employer is not eligible for this benefit. An *eligible survivor* means the surviving spouse to whom the member was married at least one year before death. A member's survivor who is eligible for any other pre-retirement death benefit may choose to receive that death benefit instead of this Optional Settlement 2 Death benefit.

Benefit

The Optional Settlement 2 Death benefit is a monthly allowance equal to the service retirement benefit that the member would have received had the member retired on the date of his or her death and elected 100% to continue to the eligible survivor after the member's death. The allowance is payable as long as the surviving spouse lives, at which time it is continued to any unmarried child(ren) under age 18, if applicable. The total amount paid will be at least equal to the basic death benefit.

Special Death Benefit

This is a standard benefit for Safety members except those described in Section 20423.6. For excluded Safety members and all Miscellaneous members, employers have the option of providing this benefit.

Eligibility

An employee's *eligible survivor(s)* may receive the special death benefit if the member dies while actively employed and the death is job-related. A CalPERS member who is no longer actively employed with **any** CalPERS employer is not eligible for this benefit. An *eligible survivor* means the surviving spouse to whom the member was married prior to the onset of the injury or illness that resulted in death. If there is no eligible spouse, an eligible survivor means the member's unmarried child(ren) under age 22. An eligible survivor who chooses to receive this benefit will not receive any other death benefit.

Benefit

The special death benefit is a monthly allowance equal to 50% of final compensation and will be increased whenever the compensation paid to active employees is increased but ceasing to increase when the member would have attained age 50. The allowance is payable to the surviving spouse until death at which time the allowance is continued to any unmarried child(ren) under age 22. There is a guarantee that the total amount paid will at least equal the basic death benefit.

If the member's death is the result of an accident or injury caused by external violence or physical force incurred in the performance of the member's duty, and there are *eligible* surviving child(ren) (*eligible* means unmarried child(ren) under age 22) in addition to an eligible spouse, then an **additional monthly allowance** is paid equal to the following:

- if 1 eligible child: 12.5% of final compensation
- if 2 eligible children: 20.0% of final compensation
- if 3 or more eligible children: 25.0% of final compensation

Back to Agenda Back to Item

Alternate Death Benefit for Local Fire Members

This is an optional benefit available only to local fire members.

Eligibility

An employee's *eligible survivor(s)* may receive the alternate death benefit in lieu of the basic death benefit or the 1957 Survivor benefit if the member dies while actively employed and has at least 20 years of total CalPERS service. A CalPERS member who is no longer actively employed with **any** CalPERS employer is not eligible for this benefit. An *eligible survivor* means the surviving spouse to whom the member was married prior to the onset of the injury or illness that resulted in death. If there is no eligible spouse, an eligible survivor means the member's unmarried child(ren) under age 18.

Benefit

The Alternate Death benefit is a monthly allowance equal to the service retirement benefit that the member would have received had the member retired on the date of his or her death and elected Optional Settlement 2. (A retiree who elects Optional Settlement 2 receives an allowance that has been reduced so that it will continue to be paid after his or her death to a surviving beneficiary.) If the member has not yet attained age 50, the benefit is equal to that which would be payable if the member had retired at age 50, based on service credited at the time of death. The allowance is payable as long as the surviving spouse lives, at which time it is continued to any unmarried child(ren) under age 18, if applicable. The total amount paid will be at least equal to the basic death benefit.

Cost-of-Living Adjustments (COLA)

Standard Benefit

Retirement and survivor allowances are adjusted each year in May for cost of living, beginning the second calendar year after the year of retirement. The standard cost-of-living adjustment (COLA) is 2%. Annual adjustments are calculated by first determining the lesser of 1) 2% compounded from the end of the year of retirement or 2) actual rate of price inflation. The resulting increase is divided by the total increase provided in prior years. For any given year, the COLA adjustment may be less than 2% (when the rate of price inflation is low), may be greater than the rate of price inflation (when the rate of price inflation is low after several years of high price inflation) or may even be greater than 2% (when price inflation is high after several years of low price inflation).

Improved Benefit

Employers have the option of providing a COLA of 3%, 4%, or 5%, determined in the same manner as described above for the standard 2% COLA. An improved COLA is not available with the 1.5% at 65 formula.

Purchasing Power Protection Allowance (PPPA)

Retirement and survivor allowances are protected against price inflation by PPPA. PPPA benefits are cost-of-living adjustments that are intended to maintain an individual's allowance at 80% of the initial allowance at retirement adjusted for price inflation since retirement. The PPPA benefit will be coordinated with other cost-of-living adjustments provided under the plan.

Back to Agenda Back to Item

Employee Contributions

Each employee contributes toward his or her retirement based upon the retirement formula. The standard employee contribution is as described below.

- The percent contributed below the monthly compensation breakpoint is 0%.
- The monthly compensation breakpoint is $0 for full and supplemental formula members and $133.33 for employees covered by the modified formula.
- The percent contributed above the monthly compensation breakpoint depends upon the benefit formula, as shown in the table below.

Benefit Formula	Percent Contributed above the Breakpoint
Miscellaneous, 1.5% at 65	2%
Miscellaneous, 2% at 60	7%
Miscellaneous, 2% at 55	7%
Miscellaneous, 2.5% at 55	8%
Miscellaneous, 2.7% at 55	8%
Miscellaneous, 3% at 60	8%
Miscellaneous, 2% at 62	50% of the Total Normal Cost
Miscellaneous, 1.5% at 65	50% of the Total Normal Cost
Safety, Half Pay at 55	Varies by entry age
Safety, 2% at 55	7%
Safety, 2% at 50	9%
Safety, 3% at 55	9%
Safety, 3% at 50	9%
Safety, 2% at 57	50% of the Total Normal Cost
Safety, 2.5% at 57	50% of the Total Normal Cost
Safety, 2.7% at 57	50% of the Total Normal Cost

The employer may choose to "pick-up" these contributions for classic members (Employer Paid Member Contributions or EPMC). EPMC is prohibited for new PEPRA members.

An employer may also include Employee Cost Sharing in the contract, where employees agree to share the cost of the employer contribution. These contributions are paid in addition to the member contribution.

Auxiliary organizations of the CSU system may elect reduced contribution rates, in which case the offset is $317 and the contribution rate is 6% if members are not covered by Social Security. If members are covered by Social Security, the offset is $513 and the contribution rate is 5%.

Refund of Employee Contributions

If the member's service with the employer ends, and if the member does not satisfy the eligibility conditions for any of the retirement benefits above, the member may elect to receive a refund of his or her employee contributions, which are credited with 6% interest compounded annually.

1959 Survivor Benefit

This is a pre-retirement death benefit available only to members not covered by Social Security. Any agency joining CalPERS subsequent to 1993 is required to provide this benefit if the members are not covered by Social Security. The benefit is optional for agencies joining CalPERS prior to 1994. Levels 1, 2, and 3 are now closed. Any new agency or any agency wishing to add this benefit or increase the current level may only choose the 4th or Indexed Level.

This benefit is not included in the results presented in this valuation. More information on this benefit is available on the CalPERS website.

Back to Agenda Back to Item

Appendix C

Participant Data

- **Summary of Valuation Data**
- **Active Members**
- **Transferred and Separated Members**
- **Retired Members and Beneficiaries**

Summary of Valuation Data

	June 30, 2021	June 30, 2022
1. **Active Members**		
a) Counts	1,377	1,443
b) Average Attained Age	44.08	44.31
c) Average Entry Age to Rate Plan	37.62	37.90
d) Average Years of Credited Service	6.43	6.38
e) Average Annual Covered Pay	$77,593	$81,328
f) Annual Covered Payroll	106,844,914	117,356,015
g) Projected Annual Payroll for Contribution Year	116,073,531	127,492,517
h) Present Value of Future Payroll	1,040,139,021	1,136,970,148
2. **Transferred Members**		
a) Counts	74	85
b) Average Attained Age	48.78	47.71
c) Average Years of Credited Service	3.37	3.78
d) Average Annual Covered Pay	$92,338	$96,639
3. **Separated Members**		
a) Counts	867	993
b) Average Attained Age	46.92	46.91
c) Average Years of Credited Service	2.94	3.22
d) Average Annual Covered Pay	$64,446	$65,953
4. **Retired Members and Beneficiaries**		
a) Counts	180	203
b) Average Attained Age	68.72	69.11
c) Average Annual Benefits	$18,375	$19,752
d) Total Annual Benefits	$3,307,488	$4,009,654
5. **Active to Retired Ratio** [(1a) / (4a)]	7.65	7.11

Counts of members included in the valuation are counts of the records processed by the valuation. Multiple records may exist for those who have service in more than one valuation group. This does not result in double counting of liabilities.

Average Annual Benefits represents benefit amounts payable by this plan only. Some members may have service with another agency and would therefore have a larger total benefit than would be included as part of the average shown here.

Active Members

Counts of members included in the valuation are counts of the records processed by the valuation. Multiple records may exist for those who have service in more than one valuation group. This does not result in double counting of liabilities.

Distribution of Active Members by Age and Service

	Years of Service at Valuation Date						
Attained Age	**0-4**	**5-9**	**10-14**	**15-19**	**20-24**	**25+**	**Total**
15-24	16	0	0	0	0	0	16
25-29	98	10	0	0	0	0	108
30-34	146	75	2	0	0	0	223
35-39	123	105	15	4	0	0	247
40-44	76	83	25	13	3	0	200
45-49	70	79	23	15	7	5	199
50-54	65	57	20	9	7	3	161
55-59	36	61	25	10	6	9	147
60-64	19	37	10	8	4	5	83
65 and Over	15	22	10	6	2	4	59
All Ages	**664**	**529**	**130**	**65**	**29**	**26**	**1,443**

Distribution of Average Annual Salaries by Age and Service

	Years of Service at Valuation Date						
Attained Age	**0-4**	**5-9**	**10-14**	**15-19**	**20-24**	**25+**	**Average Salary**
15-24	$54,559	$0	$0	$0	$0	$0	$54,559
25-29	52,331	52,669	0	0	0	0	52,362
30-34	62,321	63,655	76,068	0	0	0	62,893
35-39	73,822	76,802	82,993	66,364	0	0	75,525
40-44	78,621	83,554	99,092	80,867	85,253	0	83,473
45-49	84,261	86,851	84,648	92,705	115,649	64,599	86,580
50-54	79,202	91,972	96,522	98,448	82,343	87,186	87,236
55-59	95,295	94,373	108,990	114,811	136,041	91,753	100,015
60-64	122,304	95,165	131,932	108,118	132,878	139,521	111,545
65 and Over	114,807	99,001	112,433	96,652	77,364	114,936	105,404
Average	**$73,311**	**$82,910**	**$99,385**	**$95,174**	**$108,420**	**$98,757**	**$81,328**

Transferred and Separated Members

Distribution of Transfers to Other CalPERS Plans by Age, Service, and average Salary

	Years of Service at Valuation Date							
Attained Age	**0-4**	**5-9**	**10-14**	**15-19**	**20-24**	**25+**	**Total**	**Average Salary**
15-24	0	0	0	0	0	0	0	$0
25-29	9	0	0	0	0	0	9	65,505
30-34	5	1	0	0	0	0	6	54,382
35-39	9	0	0	0	0	0	9	83,086
40-44	10	2	0	0	0	0	12	87,290
45-49	7	1	0	0	0	0	8	92,080
50-54	11	3	0	0	1	0	15	107,425
55-59	6	1	2	0	0	0	9	130,713
60-64	5	3	1	2	0	0	11	99,322
65 and Over	4	2	0	0	0	0	6	147,718
All Ages	**66**	**13**	**3**	**2**	**1**	**0**	**85**	**$96,639**

Distribution of Separated Participants with Funds on Deposit by Age, Service, and average Salary

	Years of Service at Valuation Date							
Attained Age	**0-4**	**5-9**	**10-14**	**15-19**	**20-24**	**25+**	**Total**	**Average Salary**
15-24	2	0	0	0	0	0	2	$41,780
25-29	45	0	0	0	0	0	45	44,319
30-34	100	19	1	0	0	0	120	51,450
35-39	110	26	5	0	0	0	141	55,175
40-44	112	30	2	1	0	0	145	58,811
45-49	104	28	14	2	0	0	148	70,166
50-54	102	30	5	2	3	0	142	77,359
55-59	72	25	6	2	1	2	108	78,258
60-64	65	8	4	1	1	0	79	77,042
65 and Over	60	3	0	0	0	0	63	79,756
All Ages	**772**	**169**	**37**	**8**	**5**	**2**	**993**	**$65,953**

Retired Members and Beneficiaries

Distribution of Retirees and Beneficiaries by Age and Retirement Type*

Attained Age	Service Retirement	Non-Industrial Disability	Industrial Disability	Non-Industrial Death	Industrial Death	Death After Retirement	Total
Under 30	0	0	0	0	0	0	0
30-34	0	0	0	0	0	0	0
35-39	0	0	0	0	0	0	0
40-44	0	0	0	0	0	0	0
45-49	0	0	0	0	0	0	0
50-54	3	0	0	0	0	0	3
55-59	12	0	0	0	0	1	13
60-64	33	0	0	0	0	1	34
65-69	65	0	0	0	0	0	65
70-74	57	0	0	0	0	2	59
75-79	17	0	0	0	0	0	17
80-84	10	0	0	0	0	1	11
85 and Over	1	0	0	0	0	0	1
All Ages	**198**	**0**	**0**	**0**	**0**	**5**	**203**

Distribution of Average Annual Disbursements to Retirees and Beneficiaries by Age and Retirement Type*

Attained Age	Service Retirement	Non-Industrial Disability	Industrial Disability	Non-Industrial Death	Industrial Death	Death After Retirement	Average
Under 30	$0	$0	$0	$0	$0	$0	$0
30-34	0	0	0	0	0	0	0
35-39	0	0	0	0	0	0	0
40-44	0	0	0	0	0	0	0
45-49	0	0	0	0	0	0	0
50-54	18,390	0	0	0	0	0	18,390
55-59	15,063	0	0	0	0	13,244	14,923
60-64	20,308	0	0	0	0	11,272	20,042
65-69	20,496	0	0	0	0	0	20,496
70-74	20,991	0	0	0	0	8,804	20,578
75-79	16,388	0	0	0	0	0	16,388
80-84	20,595	0	0	0	0	39,290	22,294
85 and Over	8,871	0	0	0	0	0	8,871
All Ages	**$19,840**	**$0**	**$0**	**$0**	**$0**	**$16,283**	**$19,752**

Back to Agenda Back to Item

Retired Members and Beneficiaries (continued)

Distribution of Retirees and Beneficiaries by Years Retired and Retirement Type*

Years Retired	Service Retirement	Non-Industrial Disability	Industrial Disability	Non-Industrial Death	Industrial Death	Death After Retirement	Total
Under 5 Yrs	88	0	0	0	0	3	91
5-9	61	0	0	0	0	1	62
10-14	26	0	0	0	0	0	26
15-19	20	0	0	0	0	1	21
20-24	3	0	0	0	0	0	3
25-29	0	0	0	0	0	0	0
30 and Over	0	0	0	0	0	0	0
All Years	**198**	**0**	**0**	**0**	**0**	**5**	**203**

Distribution of Average Annual Disbursements to Retirees and Beneficiaries by Years Retired and Retirement Type*

Years Retired	Service Retirement	Non-Industrial Disability	Industrial Disability	Non-Industrial Death	Industrial Death	Death After Retirement	Average
Under 5 Yrs	$21,501	$0	$0	$0	$0	$21,776	$21,510
5-9	20,924	0	0	0	0	11,272	20,769
10-14	19,552	0	0	0	0	0	19,552
15-19	11,647	0	0	0	0	4,812	11,322
20-24	6,168	0	0	0	0	0	6,168
25-29	0	0	0	0	0	0	0
30 and Over	0	0	0	0	0	0	0
All Years	**$19,840**	**$0**	**$0**	**$0**	**$0**	**$16,283**	**$19,752**

* Counts of members do not include alternate payees receiving benefits while the member is still working. Therefore, the total counts may not match information on C-1 of the report. Multiple records may exist for those who have service in more than one coverage group. This does not result in double counting of liabilities.

Back to Agenda Back to Item

Appendix D

Glossary

Glossary

Accrued Liability (Actuarial Accrued Liability)
The Present Value of Benefits minus the present value of future Normal Cost or the Present Value of Benefits allocated to prior years. Different actuarial cost methods and different assumptions will lead to different measures of Accrued Liability.

Actuarial Assumptions
Assumptions made about certain events that will affect pension costs. Assumptions generally can be broken down into two categories: demographic and economic. Demographic assumptions include such things as mortality, disability, and retirement rates. Economic assumptions include discount rate, wage inflation, and price inflation.

Actuarial Methods
Procedures employed by actuaries to achieve certain funding goals of a pension plan. Actuarial methods include an actuarial cost method, an amortization policy, and an asset valuation method.

Actuarial Valuation
The determination as of a valuation date of the Normal Cost, Accrued Liability, and related actuarial present values for a pension plan. These valuations are performed annually or when an employer is contemplating a change in plan provisions.

Actuary
A business professional proficient in mathematics and statistics who measures and manages risk. A public retirement system actuary in California performs actuarial valuations necessary to properly fund a pension plan and disclose its liabilities and must satisfy the *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States* with regard to pensions.

Amortization Bases
Separate payment schedules for different portions of the Unfunded Accrued Liability (UAL). The total UAL of a rate plan can be segregated by cause. The impact of such individual causes on the UAL are quantified at the time of their occurrence, resulting in new amortization bases. Each base is separately amortized and paid for over a specific period of time. Generally, in an actuarial valuation, the separate bases consist of changes in UAL due to contract amendments, actuarial assumption changes, method changes, and/or gains and losses.

Amortization Period
The number of years required to pay off an Amortization Base.

Classic Member (under PEPRA)
A member who joined a public retirement system prior to January 1, 2013 and who is not defined as a new member under PEPRA. (See definition of New Member below.)

Discount Rate
This is the rate used to discount the expected future benefit payments to the valuation date to determine the Projected Value of Benefits. Different discount rates will produce different measures of the Projected Value of Benefits. The discount rate for funding purposes is based on the assumed long-term rate of return on plan assets, net of investment and administrative expenses. This rate is called the “actuarial interest rate” in Section 20014 of the California Public Employees’ Retirement Law.

Entry Age
The earliest age at which a plan member begins to accrue benefits under a defined benefit pension plan. In most cases, this is the age of the member on their date of hire.

Entry Age Actuarial Cost Method
An actuarial cost method that allocates the cost of the projected benefits on an individual basis as a level percent of earnings for the individual between entry age and retirement age. This method yields a total normal cost rate, expressed as a percentage of payroll, which is designed to remain level throughout the member’s career.

Fresh Start
A Fresh Start is when multiple amortization bases are combined into a single base and amortized over a new Amortization Period.

Glossary (continued)

Funded Ratio
Defined as the Market Value of Assets divided by the Accrued Liability. Different actuarial cost methods and different assumptions will lead to different measures of Funded Ratio. The Funded Ratio with the Accrued Liability equal to the funding target is a measure of how well funded a rate plan is. A ratio greater than 100% means the rate plan has more assets than the funding target and the employer need only contribute the Normal Cost. A ratio less than 100% means assets are less than the funding target and contributions in addition to Normal Cost are required.

Funded Status
Any comparison of a particular measure of plan assets to a particular measure of pension obligations. The methods and assumptions used to calculate a funded status should be consistent with the purpose of the measurement.

Funding Target
The Accrued Liability measure upon which the funding requirements are based. The funding target is the Accrued Liability under the Entry Age Actuarial Cost Method using the assumptions adopted by the board.

GASB 68
Statement No. 68 of the Governmental Accounting Standards Board. The accounting standard governing a state or local governmental employer's accounting and financial reporting for pensions.

New Member (under PEPRA)
A new member includes an individual who becomes a member of a public retirement system for the first time on or after January 1, 2013, and who was not a member of another public retirement system prior to that date, and who is not subject to reciprocity with another public retirement system.

Normal Cost
The portion of the Present Value of Benefits allocated to the upcoming fiscal year for active employees. Different actuarial cost methods and different assumptions will lead to different measures of Normal Cost. The Normal Cost under the Entry Age Actuarial Cost Method, using the assumptions adopted by the board, plus the required amortization of the UAL, if any, make up the required contributions.

PEPRA
The California Public Employees' Pension Reform Act of 2013.

Present Value of Benefits (PVB)
The total dollars needed as of the valuation date to fund all benefits earned in the past or expected to be earned in the future for *current* members.

Traditional Unit Credit Actuarial Cost Method
An actuarial cost method that sets the Accrued Liability equal to the Present Value of Benefits assuming no future pay increases or service accruals. The Traditional Unit Credit Cost Method is used to measure the accrued liability on a termination basis.

Unfunded Accrued Liability (UAL)
The Accrued Liability minus the Market Value of Assets. If the UAL for a rate plan is positive, the employer is required to make contributions in excess of the Normal Cost.

CalOptima Health Board Action Agenda Referral

Action To Be Taken September 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

20. Approve Actions Related to the Garden Grove Street Medicine Pilot Program and Support Center

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, (714) 954-2140

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to:
    a. Solicit, select and contract for general contractor services and furniture, fixtures, and equipment for the Street Medicine Support Center at 7900 Garden Grove Boulevard, Garden Grove, California.
    b. Execute a contract amendment with Totum Corporation to complete full scope design, including assessments, architecture and engineering, project management, local engagement, permits, and fees for the Street Medicine Support Center at 7900 Garden Grove Boulevard, Garden Grove, California for the nine-month period of September 1, 2023, through May 31, 2024.
    c. Execute a contract amendment with RiverRock Real Estate Group, Inc. (RiverRock) for property management, maintenance and security services at 7900 Garden Grove Boulevard for the nine-month period of September 1, 2023, through May 31, 2024.
2. Authorize unbudgeted expenditures in an amount up to $10.51 million in undesignated reserves to fund the Recommended Action 1.
3. Authorize the CEO to negotiate an amendment to the existing contract with Healthcare in Action to include additional services to be provided at the Street Medicine Support Center.
4. Make exceptions to CalOptima Health Policy GA.5002: Purchasing Policy related to Recommended Actions 1b, 1c, and 3.

Background

On March 17, 2022, CalOptima Health's Board (Board) committed $8 million from the Homeless Health Initiatives Reserve for purposes of Street Medicine. On May 5, 2022, CalOptima Health's Board approved the Street Medicine scope of work (SOW). On November 3, 2022, CalOptima Health's Board authorized the CEO to execute a contract with Healthcare In Action to provide street canvasing-based medical services. The Street Medicine pilot program launched in Garden Grove on April 1, 2023.

In order to design a comprehensive Street Medicine Program, on May 4, 2023, the Board authorized staff to develop a proposal to include a Street Medicine Support Center and locate a property in the City of Garden Grove (City), the location of the pilot program. Staff entered into a Purchase and Sale Agreement on May 26, 2023. On June 27, 2023, the City unanimously supported a Memorandum of Understanding (MOU), between the City and CalOptima Health to partner and support the establishment of a Street Medicine Support Center. On June 29, 2023, CalOptima approved said MOU with the City and entered into the escrow period to purchase the Street Medicine Support Center.

Back to Agenda

Discussion

CalOptima Health is currently in escrow to acquire the real property located at 7900 Garden Grove Boulevard, Garden Grove, California, with plans to repurpose the property's use as the initial Street Medicine Support Center. The Street Medicine Support Center will feature 52 private guest rooms that will serve 52 members. Each guest room will be furnished and will include a kitchenette and a bathroom. The Street Medicine Support Center will also include staff administrative offices, laundry facilities, and an outdoor open space. The Street Medicine Support Center will offer priority placement to older adults, families, and veterans of the Street Medicine Program. Participants will receive three-meals a day, and on-site security will be provided 24 hours a day. While there is no limit of stay, it is estimated that individuals will remain for approximately 90 days.

Preconstruction Property Management

A. Contract Amendment with RiverRock

From the time of close of escrow and assumption of the property, the securing of the vacant, unmanned site and adequate response to protect the asset becomes the responsibility of CalOptima Health. RiverRock is currently contracted to provide security and maintenance services to all other CalOptima Health real estate assets. It is recommended, for timely and adequate implementation of security and any required safety maintenance, that RiverRock's agreement be amended to include the Street Medicine Support Center for a not-to-exceed period of nine (9) months to provide the minimum services required until the start of construction, at which time the awarded General Contractor assumes control of the site. To implement this recommendation, an amendment to add the Street Medicine Support Center property and an expanded SOW for the site to the existing RiverRock contract is required. The estimated fiscal impact of the contract amendment for September 1, 2023, through May 31, 2024, is $380,000.

B. Preparation Activities Contracts

To support preconstruction property management, staff will contract directly for certain services related to the preparation activities needed prior to construction using the bidding exception in Section II.P of the purchasing policy. The estimated fiscal impact of these contracts is $130,000.

Redevelopment Costs

Once design plans and permitting are completed, construction on the Street Medicine Support Center will begin. CalOptima Health estimates the total redevelopment cost at $10.0 million. The following table provides additional details:

Cost Category	**Estimate (in millions)**
1. Soft Costs (full scope design, including assessments, architecture and engineering, project management, local engagement, permits, and fees)	$1.4
2. Hard Costs (construction and building equipment)	$6.6
3. Furniture, Fixtures, & Equipment (FFE) (i.e., medical equipment, furniture, linens, etc.)	$0.3
4. Contingency (25%)	$1.7
TOTAL	**$10.0**

Back to Agenda

CalOptima Health requests that the Board authorize the CEO to solicit, select, and contract for the Hard Costs and FFE redevelopment costs using CalOptima Health's procurement process. The current plan is to open the Street Medicine Support Center by Spring 2025.

Totum Contract Amendment

Staff recommends authorizing the CEO to execute an amendment to the existing contract with Totum to expand the SOW for a nine-month period of September 1, 2023, through May 31, 2024, to complete services related to soft costs for the Street Medicine Support Center. The Board authorized the CEO to contract with Totum at its February 2, 2023, meeting to complete soft costs for the proposed Community Living and PACE Center in the City of Tustin. Due to the timing of development of the Street Medicine Support Center, staff recommends the continued use of Totum's expertise to effectively complete this project.

Healthcare In Action Contract Amendment

The Street Medicine Support Center is an extension of the Garden Grove Street Medicine Program. Enrolled patients who are willing to leave the street will be able to temporarily receive shelter along with the continued medical and wrap-around services of the Street Medicine Program at the Street Medicine Support Center. For continuity of Street Medicine Program services, Healthcare in Action, as the provider of street medicine, will also need to manage the Street Medicine Support Center. In order to implement this, an expanded SOW to the existing Healthcare in Action contract is needed. Staff recommends authorizing the CEO to negotiate an amendment to the existing contract with Healthcare In Action to include an expanded SOW. Staff will return to the Board with additional recommendations related to the contract amendment and program implementation at a future meeting.

Exceptions to CalOptima Health Policy GA.5002: Purchasing Policy

Staff requests that the Board authorize the following exceptions in the Purchasing Policy.

- Due to the immediate need to protect CalOptima Health's asset and to address safety and security concerns, staff believes the most expedient option is to engage the current contracted vendor, RiverRock, to provide security and maintenance services for a nine-month period at the Street Medicine Support Center.

- Due to timing of the development of the Street Medicine Support Center, staff recommends amending the existing contract with Totum to complete soft costs for the project.

- In order to maintain continuity of care for the provision of health care and related services to our members enrolled in the Garden Grove Street Medicine Program, staff recommends engaging Healthcare In Action to manage services at the Street Medicine Support Center using the bidding exception in Section II.P of the purchasing policy.

Staff requests that the Board authorize funding in an amount up to $10.51 million from undesignated reserves to fund the actions at the Street Medicine Support Center and the contract amendments with Totum and RiverRock, as well as the ability for the CEO to proceed with various contracts and/or contract amendments to develop a comprehensive Street Medicine Program and Support Center.

Back to Agenda

Fiscal Impact
The recommended actions are unbudgeted. An appropriation of up to $10.51 million in undesignated reserves will fund these actions. Staff is requesting this authority subject to the Board of Directors approving purchase of the property for the Street Medicine Support Center.

Rationale for Recommendation
The recommended actions will allow CalOptima Health to develop the Street Medicine Support Center according to its mission and vision. Additionally, allowing the CEO to negotiate an expanded SOW with Healthcare in Action will allow for the necessary expansion of the Garden Grove Street Medicine Program.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
1. Entities Covered by this Recommended Board Action

/s/ Michael Hunn *08/31/2023*
Authorized Signature **Date**

Back to Agenda

Attachment to the September 7, 2023 Board of Directors Meeting – Agenda Item 20

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Healthcare in Action	3800 Kilroy Airport Way, Suite 100	Long Beach	CA	90806
RiverRock	505 City Parkway West, Suite 160	Orange	CA	92868
Totum Corporation	15130 Ventura Blvd., Suite A	Sherman Oaks	CA	91403

Back to Agenda Back to Item

Board of Directors Meeting
September 7, 2023

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

Report to the Board

The Member Advisory Committee (MAC), and the Provider Advisory Committee (PAC) held a regular joint meeting on August 10, 2023, to discuss topics of mutual interest.

MAC approved a recommendation to the Board for the appointment of Nicole Mastin as the CalWORKs Representative.

Michael Hunn, Chief Executive Officer, provided an update on the on-going redetermination initiative being undertaken from the Orange County Social Services Agency. He noted that the Department of Health Care Services (DHCS) is preparing to put forth several reports that would show how high CalOptima Health and other organizations ranked in the state with regards to the services offered through CalAIM. Mr. Hunn also updated the committees on the efforts being undertaken with redetermination and noted that CalOptima Health was getting a lot of recognition because of the substantial partnership with the Orange County Social Service Agency to get the word out to members with regards to enrolling. This was evidenced by the attendance of over 4,200 individuals at the event held at Ponderosa Park in July that were assisted by over 50 volunteers to help them sign up for benefits.

Yunkyung Kim, Chief Operating Officer, notified the committees that due to a Board resignation, the Member Representative seat on the CalOptima Health Board was available and that the Orange County Health Care Agency would be recruiting for this seat as soon as possible and asked the committees to share the news of the opening. She also provided the committee with some updates on questions by the members that pertained to deeming periods should a member lose their benefits through CalOptima Health.

Richard Pitts, D.O., Ph.D., Chief Medical Officer, provided updates on the resurgence of the MPox virus and noted that there was an active vaccination program that was available. Dr. Pitts also reviewed the resurgence of COVID, but also noted that hospitalizations in Orange County were still at normal rates. He also discussed the recent Board decision to provide $15M in funds to purchase Naloxone for CalOptima Health members to combat the Fentanyl crisis going on in Orange County.

Jewel Loff, Program Director, MATCONNECT, presented on Medication-Assisted Treatment (MAT). She noted that MAT is the use of FDA-approved medications for alcohol and opioid use disorder, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the

treatment of substance use disorders. With the assistance of the Orange County Coalition of Community Health Centers the goal of MAT is to assist individuals to fully recover from substance use disorder, including the ability to live a self-directed life.

Donna Laverdiere, Executive Director, Strategic Development presented on Workforce Development Grant Initiative – Stakeholder Discussion with the committees to gather their input and ideas that would best serve the community. Ms. Laverdiere noted that CalOptima Health's Board had approved an investment of $50 million over five years for Health Provider Workforce Development. A robust discussion ensued, and the members agreed to submit via email suggestions for what is needed in the health care community.

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